

Bundle Finance and Performance OPEN 18 July 2022

Agenda attachments

ITEM 0 Open F and P Agenda - 18 July 2022.docx

- 0 09:30 - OPENING ITEMS
- 1 Chair's welcome, apologies, and confirmation of quorum
- 2 Declarations of interest
- 3 Minutes of last meeting
ITEM 3 OPEN F and P Minutes 16 May 2022 TM and CT.doc
- 4 Action log and matters arising
ITEM 4 F and p Committee Action Log.docx
- 5 09:35 - Operations Quarterly Report
ITEM 5 Ops Directorate Quarterly Report for Committees 22-23 Q1 (Jul22) FINAL.pdf
- 5.1 ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION
- 6 09:45 - Financial Position for Month 3 - Presentation on the day
- 7 09:55 - Financial sustainability work programme
ITEM 7 SBAR_Financial Sustainability Workstreams 18th July FP.docx
ITEM 7.1 Annex 1 Financial Sustainability Workstreams Terms of Reference V 1.3 270622.docx
- 8 10:10 - Monthly Integrated Quality and Performance Report
ITEM 8 MIQPR SBAR May June 2022.docx final.docx
ITEM 8.1 Appendix 1 Metrics review july 2022.pptx
ITEM 8.2 Annex 1 MIQPR May June 2022.pptx final.pdf
- 9 10:30 - IMTP Delivery Update
ITEM 9 Executive Summary - IMTP 2021-22 Delivery Tracker _FandP_180722.docx
ITEM 9.1 Appendix 1_IMTP Delivery Programmes Assurance Report Q1 2022_23.docx
ITEM 9.2 Appendix 2A IMTP Q1 Delivery Tracker Detail - Ambitions F_and_P.docx
ITEM 9.3 Appendix 2B IMTP Q1 Delivery Tracker Detail - Enablers F_and_P.docx
- 10 10:40 - Risk Management and Corporate Risk Register
ITEM 10 ES Risk Management and BAF Report.docx
- 11 10:50 - Decarbonisation and Sustainability Update
ITEM 11 FPC update July 22 06.07.22 v0.2.docx
- 12 11:00 - Internal Audit Tracker Report and related audits (Item 12.2 - Audit Tracker Circulated separately)
ITEM 12 ES F&P - Internal Audit Report 180722.docx
ITEM 12.2 Appendix 2 WAST Waste Management Final Report.pdf
ITEM 12.3 Appendix 3 WAST_2122-005_NIS Directive_Internal Audit Report (Final).pdf
ITEM 12.4 Appendix 4 WAST_2122-008_Service Reconfiguration_Final Internal Audit Report client issue.pdf
- 13 11:15 - Business Continuity Assessment
ITEM 13 Executive Summary for FP - Annual Business Continuity Assessment.docx
ITEM 13.1 BC Annual Assessment June 2022 V2 JH FINAL.docx
- 14 11:25 - Emergency Preparedness, Resilience and Response. Document Tracker
ITEM 14 SBAR - EPRR Document Tracker 0.1 FINAL.docx
ITEM 14.1 Executive Summary for FP - EPRR Doc Tracker.docx
- 14.1 11:35 - CLOSING ITEMS
- 15 Key messages for Board
- 16 Any other business
- 17 Date and time of next meeting; 19 September 2022 at 09:30



MEETING OF THE OPEN FINANCE AND PERFORMANCE COMMITTEE

Held on 18 July 2022 from 09:30 to 11:40

Meeting held virtually via Microsoft Teams

AGENDA

No.	Agenda Item	Purpose	Lead	Format	Time
OPENING ITEMS					
1.	Chair's welcome, apologies, and confirmation of quorum	Information	Kevin Davies	Verbal	5 Mins
2.	Declarations of interest	Information	Kevin Davies	Verbal	
3.	Minutes of last meeting	Approval	Kevin Davies	Paper	
4.	Action log and matters arising	Review	Kevin Davies	Paper	
5.	Operations Quarterly Report	Information	Lee Brooks	Paper	10 mins
ITEMS FOR APPROVAL, ASSURANCE AND DISCUSSION					
6.	Financial Position for Month 3	Assurance	Chris Turley	Presentation	10 Mins
7.	Financial sustainability work programme	Assurance Discuss	Chris Turley	Paper	15 Mins
8.	Monthly Integrated Quality and Performance Report	Assurance	Rachel Marsh	Paper	20 Mins
9.	IMTP Delivery Update	Assurance	Rachel Marsh	Paper	10 Mins
10.	Risk Management and Corporate Risk Register	Assurance	Julie Boalch	Paper	10 Mins
11.	Decarbonisation and Sustainability Update	Assurance	Chris Turley	Paper	10 Mins
12.	Internal Audit Tracker Report and related audits	Assurance	Julie Boalch	Paper	15 Mins
13.	Business Continuity Assessment		Lee Brooks	Paper	10 Mins
14.	Emergency Preparedness, Resilience and Response. Document Tracker	Assurance	Lee Brooks	Paper	10 Mins
CLOSING ITEMS					
15.	Key messages for Board	Discussion	Kevin Davies	Verbal	5 Mins
16.	Any other business	Discussion	Kevin Davies	Verbal	
17.	Date and time of next meeting; 19 September 2022 at 09:30	Information	Kevin Davies	Verbal	

Lead Presenters

Name	Position
Chris Turley	Executive Director of Finance and Corporate Resources
Kevin Davies	Chair and Non Executive Director
Lee Brooks	Director of Operations
Trish Mills	Board Secretary
Julie Boalch	Head of Risk/Deputy Board Secretary
Rachel Marsh	Director of Strategy, Planning and Performance



GIG
CYMRU
NHS
WALES | Ymddiriedolaeth GIG
Gwasanaethau Ambiwllans Cymru
Welsh Ambulance Services
NHS Trust

Andy Haywood	Director of Digital
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UNCONFIRMED MINUTES OF THE MEETING OF THE FINANCE AND PERFORMANCE COMMITTEE (OPEN SESSION) HELD ON 16 May 2022 VIA TEAMS

Chair: Professor Kevin Davies

PRESENT :

Professor Kevin Davies	Non Executive Director
Bethan Evans	Non Executive Director
Ceri Jackson	Non Executive Director
Joga Singh	Non Executive Director

IN ATTENDANCE:

Julie Boalch	Head of Risk and Deputy Board Secretary
Lee Brooks	Director of Operations
Dr Catherine Goodwin	Interim Director of Workforce and Organisational Development
Rhian Davies	Graduate Trainee, HEIW
Andy Haywood	Director of Digital Services
Navin Kalia	Deputy Director of Finance and Corporate Resources
Rhian Lewis	Internal Audit NWSSP
Rachel Marsh	Director of Strategy, Planning and Performance
Trish Mills	Board Secretary
Steve Owen	Corporate Governance Officer
Hugh Parry	Trade Union Partner
Chris Turley	Executive Director of Finance and Corporate Resources
Jonathan Turnbull-Ross	Assistant Director of Quality Governance
Damon Turner	Trade Union Partner
Keith Williams	Head of Operational Communications Programme

APOLOGIES

Wendy Herbert	Interim Director of Quality and Nursing
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30/22 PROCEDURAL MATTERS

The Chair welcomed all to the meeting and reminded attendees that the meeting was being audio recorded. The declaration of interests in respect of Professor Kevin Davies as a Trustee of St John Cymru and Ceri Jackson as a Trustee of the Stroke Association were noted.

Minutes

The minutes of the open session held on 17 March 2022 were considered by the Committee and agreed as a correct record.

Action Log

The action log was considered: There were no actions due for this meeting

RESOLVED: That

- (1) **the Minutes of the meeting held on 17 March 2022 were confirmed as a correct record; and**
- (2) **the declaration of interests as stated were noted.**

31/22 OPERATIONS QUARTERLY REPORT

Lee Brooks provided an update to the report and drew the Committee's attention to the following:

1. The Committee were updated on the project to implement a new Control Room solution for Integrated Communication Control Systems. Due to an issue within the system, the implementation will now be delayed with potential for a go live on 30 September 2022.
2. The new Emergency Communication Nurse System (ECNS) was due to go live on 17 May 2022.
3. In terms of the Mobile Testing Unit (MTU), closure of this programme was expected by 30 June 2022. However this may continue beyond that on a limited scale.

Comments:

Members welcomed the report recognising it had previously been discussed at the recent Quest and People and Culture Committee meetings.

RESOLVED: That the Committee noted the report.

32/22 FINANCIAL PERFORMANCE YEAR END 2021/22

Chris Turley gave an overview of the report and brought the following highlights to the Committee's attention:

1. The Trust had reported a small revenue surplus (£75k) for the 2021/22 financial year (subject to audit)
2. Capital expenditure was fully spent in line with updated plans.
3. In line with the financial plans that support the Integrated Medium Term Plan (IMTP) gross savings of £2.861m have been achieved against a target of £2.800m.
4. Public Sector Payment Policy was on track with performance, against a target of 95%, of 97.2% for the number, and 98.4% of the value of non NHS invoices paid within 30 days.

Comments:

1. The Committee recognised and congratulated the work of the Finance Team for their work in delivering a balanced budget during this challenging year; notably the short

turnaround of projects.

2. In respect of spending by directorate which was variable, going forward should this continue there may be challenges? Chris Turley explained that there would be more focus on the savings delivery at a directorate level.

RESOLVED: The Committee reviewed, noted and received assurance on the financial out turn position of the Trust for 2021/22, subject to audit and ahead of the Trust Board presentation of the 2021/22 accounts in June 2022

33/22 FINANCIAL POSITION FOR MONTH 1

The Committee were provided with a presentation on the month 1 financial performance position of the Trust adding that a more detailed report would be submitted to the Board next week; of particular note were:

1. The Month 1 revenue financial position reported was a small underspend against budget of £0.004m.
2. The forecast for 2022/23 was currently one of breakeven.
3. Capital expenditure was forecast to be fully spent.
4. In line with the financial plans that supported the Integrated Medium Term Plan, gross savings of £0.342m have been achieved against an initial monthly target of £0.371m.
5. Public Sector Payment Policy was formally reported quarterly but monitored by exception in conjunction with the Trust's shared services partners in month.
6. In terms of financial performance by directorate, there was one level of income which had not yet been confirmed and this was the £1.84m in regards to the backfill costs to cover the additional 36 clinicians in the Clinical Support Desk. This was being offset by the underspend of holding 46 WTEs ACA2 vacancies in the operations directorate.
7. The Trust is assuming, as confirmed by WG as part of the 2022/23 financial planning guidance that the additional costs as a result of exceptional cost pressures and some of the continuing costs of Covid; a current estimated total annual cost of £6.833m, would be funded.
8. There were several financial risks to the year-end balanced position which would be revised and monitored through the approaching months.

Comments:

1. In terms of holding vacancies as an effectiveness measure, was this efficient? Chris Turley explained that the vacancies were being held until the funding became available. Lee Brooks advised there would be consequences should the funding not materialise as the workforce plan would have to be re-evaluated. He added that the 'shift' of personnel to the Clinical Support Desk offered a more enhanced opportunity for managing demand and sat well with the Trust's ambition of shifting left by doing more up front for patients.
2. Were there any lessons to be learned with Personal Protective Equipment (PPE) in a post Covid environment? Chris Turley commented there would be a continuing cost of

approximately £1m per annum for increased usage of PPE.

3. Was there any impact on the Same Day Emergency Care Appointments implementation in the Hywel Dda area? Lee Brooks advised it was too early to indicate if there was any impact thus far.

RESOLVED: That the update was noted.

34/22 POST PRODUCTION LOST HOURS (PPLH) – DEEP DIVE REPORT

1. It was recognised that the Committee had requested a deep dive on PPLH (the number of hours lost due to ambulance vehicles being unavailable to respond to an incident due to a variety of reasons) at this meeting to ensure the efficiencies to be gained by some of the initiatives to reduce PPLH were balanced and proportionate.
2. Recent dialogue with Trade Union partners had raised a concern in respect of data accuracy; further work was therefore undertaken to resolve this issue which was still continuing.
3. Lee Brooks explained that PPLH was complex; there were 16 different reasons or codes for PPLH, many of which were unavoidable e.g. traumatic incident stand down, and not all of which were considered to contribute to PPLH.
4. The PPLH module within the Computer Aided Dispatch system had been used and it has been identified that should there be a quick status change in resource, a code change could be missed and therefore there were long episodes of the last code identified. Following this, the Health Informatics team have now deferred to use the resource log data; this has now enhanced the accuracy and quality of reporting. It should be borne in mind that this was a temporary fix until such time the PPLH module issue was resolved. A new Standard Operating Procedure was being developed which will set out the application of the codes which have since been refined. It was anticipated that the final solution would be completed soon.
5. The most significant loss of PPLH were the return to base rest breaks. Returning to base for a rest break which was extended beyond the rest break window (two periods of break in a 12-hour shift) was counted as PPLH and the system pressures meant that many crews were unable to return to base for their set rest break due to handover delays. Often once they had handed over their patient at the Emergency Department they were immediately stood down for a rest break, becoming unavailable to attend any incident. The average time to return to base for the rest break was 18 minutes 51 seconds, which was not felt unreasonable given the geography of Wales.
6. The Committee noted that PPLH in April was 7-10% of produced hours (appreciating that not all of this is avoidable as many of these hours are operationally legitimate and necessary) as compared to 30% of conveying resources lost to handover delays. Whilst reducing handover delays will have the biggest impact on efficiency it was recognized that the Trust must continue to do all it can to gain efficiencies in this area, however small.
7. In terms of benchmarking it was recognised that when compared to other services the Trust was performing favourably in respect of the proportion of vehicle hours unavailable. This had been based on figures provided by the Operational Research in Health (ORH).

8. The Trust had undertaken some modelling which considered the impact on PPLH of crew returning to the nearest ambulance station for their break as opposed to returning to base. The findings had indicated a small reduction in lost hours.
9. Rachel Marsh added that it was important for the Committee to understand the background with PPLH; recognising the Commissioner's and the Health Ministers interest in this topic. She recommended and agreed to take a similar presentation to the Emergency Ambulance Services Committee (EASC) and/or the Quality Delivery Group in due course.

Comments:

1. The Committee found the presentation of the complex matter of PPLH extremely helpful, noting that the ambulance service's logging of lost hours in this way was in place to demonstrate availability of a resource, in circumstances where hospitals do not log similar lost hours such as recording medical notes, changing PPE, debriefing etc..
2. Following a query in terms of the rest break arrangements, Lee Brooks explained that rest breaks took into consideration several aspects which included regulations, recognising the concerns for example taking a break in public view. Several discussions with TU partners have taken place and continued to do so focusing on the current rest break arrangements. Rachel Marsh added, when updating EASC, there were broadly 3 areas of efficiencies the Trust was focusing on; staff sickness, the roster review and working with TU partners.
3. From a Trade Union partner perspective Damon Turner championed the willingness of crews especially in rural areas to be interrupted to attend serious calls during their breaks. He added that should the pressure start to ease from the system there would be more opportunities for staff to take their break more flexibly.
4. In terms of the benchmarking of PPLH against other services was the Trust being compared on a like for like basis? Rachel Marsh advised the Committee that details and the reporting process of the best performing service would be provided at the next meeting.
5. In terms of crews returning to base for their breaks had the environment been considered? Rachel Marsh advised it had been noted and was a balance against service provision and carbon emissions.

RESOLVED: That the report was discussed and noted.

35/22

MONTHLY INTEGRATED QUALITY AND PERFORMANCE REPORT

Rachel Marsh presented the Committee with the March/April 2022 Monthly Integrated Quality and Performance Report (MIQPR). The Committee noted:

1. The challenges around 999 call answering times due to significant increases in demand remained.
2. 111 call answering performance saw a slight decline in April and was linked to increasing demand. Actions to improve call answering times in 111 were underway and the Committee noted that during the pandemic, additional resources to recruit call handlers was available and now an exercise was underway to determine the baseline staffing requirements.

3. Whilst clinical response times for call backs in one hour continued to perform well, improvements were now being seen for other categories of callers. However calls for the lower priority calls had deteriorated during April; in mitigating this, the Trust continued to recruit new staff.
4. The 111 work has now completed and work was underway to consider commissioning 111 as a National service; through establishing a new Board focusing on the specific commissioning of the service from the Trust's perspective.
5. Red and Amber response times had declined in March caused by an increase in patient demand and the extreme number of hours lost to hospital handover delays. Red performance had slightly improved in April, but Amber continued to deteriorate. This and other Committees would continue to monitor the capacity and efficiency actions to improve the current position. It was noted that funding had been received to support cohorting at the Morriston and Grange University hospitals and also some resource to support St John Cymru for several months. Cohorting allowed for temporary units to create additional space where ambulance staff can safely care for multiple patients. This will enable patients to be offloaded from ambulances before being transferred into the main emergency department and allow ambulance vehicles to be released to respond to calls in the community.
6. There was a significant reduction in staff abstraction levels (the % of EMS staff unavailable for rostered duties due to reasons such as annual leave, sickness etc...) in April 2022, however, they remained very high at 41% (benchmark 30%). COVID-19 has had a significant impact on abstractions with sickness abstractions being 13% in April 2022 (benchmark 5.99%). It was noted that Workforce fatigue was also an issue.
7. The Trust reported 3 National Reportable Incidents to the Delivery Unit in April 2022, compared to 7 in March 2022; and 19 patient safety incidents were referred to health boards under the "Appendix B" arrangement, compared to 7 in March 2022.
8. Despite all the efforts, initiatives and good progress within the Trust's gift, patients were still coming to harm as a result of the extreme hospital handover delays.

Comments:

1. Following a comment regarding the commissioning on the 6 goals for urgent and emergency care, Rachel Marsh commented that all Health Boards have been asked to include WAST as part of that structure. She further outlined the work of the Chief Ambulance Services Commissioner in order to reduce handover delays and make improvements.
2. Where does cohorting feature on risk registers? Lee Brooks explained it would feature as a treatment to existing risks. A Standard Operating Procedure was in existence between the relevant Health Boards and WAST in terms of the cohorting arrangements; this included a clinical sign off procedure.
3. The Chair of the Quality, Patient Experience and Safety Committee gave an overview of the discussion at the recent meeting of that Committee in regards to the current system pressures. She sketched out details of the conversation which focussed on the issues affecting both patients and staff and how the Trust could escalate this further; and equally how this would be reported to the Trust Board.
4. The Committee recognised the issue of moral injury generally and also the

consequences of clinicians seeing patients deteriorate; and the tragic outcome following a red request refusal. This was very impactful on staff and WAST need to be very mindful of this.

5. The Committee noted that the combined committee escalation report for the attention of the Board would elaborate on the discussions held at the three Committees (i.e. this Committee, Quality, Patient Experience and Safety Committee, and People and Culture Committee) and express their concerns on the gravitas of the current situation in relation to system pressures and its effect on patients and staff alike.

RESOLVED: That the March/April 2022 Integrated Quality and Performance report was considered; and

- (1) the report provided sufficient assurance;**
- (2) further remedial actions were to be undertaken through Executives**

36/22 INTEGRATED MEDIUM TERM PLAN (IMTP) DELIVERY

Rachel Marsh explained that the report confirmed the final year end position of the IMTP delivery noting it had been presented at previous settings.

RESOLVED: The Committee noted the IMTP Delivery Assurance Report and the headlines highlighted in the executive summary

36/22 RISK MANAGEMENT AND CORPORATE RISK REGISTER

Julie Boalch gave an overview of the report and drew their attention to the following:

1. There were currently 9 of the 17 corporate risks currently assigned to this Committee and they were described in detail within the report. These 9 risks had all been reviewed and rearticulated as part of the transformation programme of work.
2. Following this review, one of the risks 283 (Failure to implement the EMS Operational Transformation Programme), had increased in risk score from 12 to 15.
3. Members noted that the Trust's 2 highest scoring risks 223 (the Trust's inability to reach patients in the community causing patient harm and death) and 224 (significant handover delays outside A&E impacts on access to definitive care being delayed and affects the Trust's ability to provide a safe and effective service), whilst assigned to the Quest Committee for oversight, would be included in the next report for information, given the breadth and scope of these risks.
4. It was noted that the Executive Management Team had reviewed the risks that were being presented to the Committee.

Comments:

1. The Committee recognised that the Transformation Programme was one of the more significant risks and being escalated to a higher score was of significant relevance.
2. A minor point was raised on risk 311 (inability of the Estate to cope with the increase in FTEs) would it be preferable to use the word accommodate as opposed to cope. Julie Boalch advised this would be considered going forward.

RESOLVED: That the Committee receive assurances on the report and specifically noted:

- (1)the rearticulating of the 9 Corporate Risks assigned to the Committee for oversight; and**
- (2)the increase in score of Risk 283 from 12 to 15.**

38/22 PROJECT ASSESSMENT REVIEW REPORT – MOBILE VEHICLE DATA SOLUTION

1. A presentation was given by Andy Haywood and Keith Williams which updated the Committee on the current status with the Mobile Data Vehicle Solution (MDVS).
2. The MDVS full business case which sought to replace the Ambulance Mobile Data Terminals was submitted to Welsh Government and following ministerial advice recommending approval, the Trust was awaiting ratification of formal assent.
3. In parallel a formal Project Assessment Review (PAR) of MDVS was commissioned by Welsh Government and the Trust to provide assurance in relation to the 'funding decision' with a further PAR on 'readiness for service' due to take place in July.
4. The review team had identified six key recommendations in which Keith Williams outlined;
 - a. Resource Planning - the SRO should review project staffing to ensure that there is adequate resource to deliver the project as it enters into a critical phase of delivery.
 - b. Welsh Government scrutiny grid - the SRO should drive the completion of the scrutiny grid and engage with WG regarding approvals of the business case to ensure funding is available and can flow against a defined payment profile.
 - c. Detailed planning - The Project Team should develop a more detailed plan for the project identifying key tasks, milestones and resources required.
 - d. Contingency planning - The SRO should undertake a contingency planning session and build this into requisite plans.
 - e. Documentation - The Project Team should finalise the Project Initiation Document and other supporting project documentation.
 - f. Benefits management - The Project Team should develop a benefits register following best practice. This should include a benefits monitoring and realisation plan.
5. The Committee reviewed the action plan against the six key recommendations from the review and were assured on progress.

RESOLVED: The review and progress was noted.

DECARBONISATION AND SUSTAINABILITY UPDATE

1. Chris Turley explained that the Decarbonisation Action Plan was approved by the Committee in March 2022 and updated on progress against the plan. In updating the Committee the following points were highlighted:
2. Some of the environmental and sustainability projects had been competed with others due for completion soon
3. The delivery of the action plan presented cost pressures which would need to be considered. With the exception of a small amount of Welsh Government funding (up to £60k which will be bid for), financial support from Welsh Government was currently limited, and the Trust's financial position was recognised. There was clear risk that the Trust would not be able to support the levels of investment required to achieve sufficient carbon reduction and this would need to be managed by the Programme Board.
4. The Trust is the only Ambulance Service in the UK to have ISO14001 (Environmental Management Systems) accreditation and the annual audit would take place in August, with some minor non-conformities from last year to be progressed prior to that audit taking place.
5. Furthermore, Members were directed to a presentation on the Dobshill Carbon Neutral station which was available through ibabs.

Comments:

Was the Trust adequately prepared for any future legislation and organisationally resourced to meet the challenge? Chris Turley stated that it was difficult to judge at this stage whether WAST was ready for any future legislative changes adding that the resourcing issue had been previously well highlighted but that work was underway to recruit additional resource, again within the current financial outlook.

RESOLVED: The report was noted.

INTERNATIONAL FINANCIAL REPORTING STANDARD (IFRS) 16 - LEASE ACCOUNTING

Chris Turley presented the report and drew the Committee's attention to the following:

1. After significant delays partly due to Covid-19 the UK Government was implementing the transition for public bodies to IFRS 16 for financial years 2022/23 onwards
2. The overall funding impact following transition is intended to be neutral. Formal clarification over how this will be achieved and when transition will actually take place is still awaited from the WG.
3. There will be an impact on many activities across the Trust including estates, procurement, IT and finance functions.
4. IFRS 16 will be included as a regular agenda item within key internal meetings such as Estates/ Fleet SOP and ICMG as the Trust works through the initial transition stages until a business as usual situation was reached and these discussions would be led by

Finance.

RESOLVED: The Committee noted the update.

41/22 INTERNAL AUDIT TRACKER REPORT

Julie Boalch raised the following key points for the Committee's attention:

1. There were currently 5 high priority recommendations showing as overdue, they related to the 20/21 Clinical Contact Centres Performance Management review and the 21/22 Asset Management RAM System review. They were due to be completed between June and December 2022.
2. 6 limited assurance recommendations were overdue on the tracker, 2 had been completed, 3 were not yet due and the overdue one related to the ICT Disaster recovery review
3. The finalized internal audits in relation to the Cardiff Make Ready Depot (reasonable assurance); NEPTS Transfer of Operations – Benefits Realisation (limited assurance); and Digital Governance (reasonable assurance) were reviewed.

RESOLVED: The Committee:

- (1) Noted and consider the contents of the report,**
- (2) Considered the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to the Committee, and**
- (3) Received the 3 Internal Audit Reports that were presented to the Audit Committee in March 2022.**

42/22 KEY MESSAGES

The Chair advised that the Board would be apprised of, but not limited to the following:

1. Return to efficiency.
2. Risk to moral harm and moral injury on staff in witnessing avoidable harm.
3. Post Production Lost Hours, detailed discussion and recommended EASC was sighted
4. Acknowledging the financial position.

Date of next meeting: 18 July 2022

Finance and Performance Committee Action Log

Minute Ref	Date	Agenda Item	Action Note	Responsible	Due Date	Progress/Comment	Status
F&P 1/21-22	18 November 2021	Transferred to Quest Committee for monitoring	QuEST to undertake a focused review of performance related to clinical outcome metrics at their 17 February 2022 meeting	Andy Swinburn	11 August 2022	<p>Update from 16th November meeting: QuEST requested for confirmation as to whether this will be a standalone report or included in the performance report.</p> <p>Update for 17th February meeting: Andy Swinburn requests a revised date for this action due to ongoing pressures.</p> <p>Update for 12 May meeting: ePCR roll out has been completed last month and data collection validation is being worked through. In conjunction with this digipen decommissioning is a significant activity within the team. Once both these key elements have been settled attention will be turned to this focused review. It was anticipated this action will be completed by 11 August 2022. Duncan Robertson added that further deep dives were being undertaken on several clinical audits</p>	Open
34/22a	16 May 2022	Post Production Lost Hours - Deep Dive report	A similar presentation be given to the Commissioners	Lee Brooks Rachel Marsh	18 July 2022	<p>Update for 18 July</p> <p>The Trust has presented to commissioners in our quality and delivery meeting and have also done the same with WG in our new delivery meeting with them</p>	Complete
34/22b	16 May 2022	Post Production Lost Hours - Deep Dive report	PPLH Benchmarking, further details on the best performing service and their reporting process would be provided at the next meeting	Rachel Marsh	18 July 2022	<p>Update for 18 July</p> <p>Work is ongoing - Verbal update to be given on progress</p>	Open



OPERATIONS DIRECTORATE QUARTERLY REPORT FOR COMMITTEES 2022-23 Q1 (Apr-Jun22)

❖ NATIONAL OPERATIONS AND SUPPORT

Mobile Testing Units (MTU) Programme

Following submission of the Trust's proposal for the retention of Mobile Testing Units, Welsh Government has confirmed an extension of the contract until 31st March 2023. This contract provides for three MTU teams (one in the North and two in South) working Monday-Friday with some weekend contingency factored in should this be required.

EPRR and Specialist Operations

Her Majesty the Queen's Platinum Jubilee celebrations took place in June with a four-day weekend where members of the public celebrated across the UK. The EPRR team was part of the multi-agency planning with partners from the Welsh Police forces and our Health Board colleagues, to ensure we worked together across communities. The Trust anticipated an increase in demand and put plans in place which included additional command arrangements, MRT teams, Cycle Response Units and Alcohol Treatment Centres.

In May, our EPRR specialist and non-specialist assets took part in Exercise Celtic Consolidation - a large multi-agency exercise testing our combined response to a Manchester Arena style attack at Cardiff City Stadium. The exercise involved twenty WAST staff (including HART and SORT) working with partners from EMRTS, St John Ambulance Cymru, South Wales Police and South Wales Fire and Rescue. Further multi-agency exercises have taken place to look at our combined response to a Chemical, Biological, Nuclear and Radiological Attack in the South of Wales with a similar exercise being planned to take place in the North of Wales in July 2022. Further exercising opportunities are also planned to look at our response to specific sites, such as the Severn Tunnel.

In June, six members of staff and a DOM travelled to the Isle of Man to support the Manx Ambulance Service during this year's TT race. Our staff worked alongside the Isle of Man ambulance service staff and colleagues from Gibraltar and Guernsey. The staff who deployed reported that the experiences they had were hugely beneficial to them clinically and personally, and we look forward to a continued relationship with colleagues in the Isle of Man.

Work on the Trust's business continuity plans remains ongoing. Exercise Joshua was very successful in testing our internal response to ICT failures. This has allowed the team to produce the Trust's Critical ICT Disruption Plan. This plan was further tested via exercise Joshua 2 which took place at the end of June 2022. An exercise report shall follow.

The WAST Hazardous Area Response Team (HART) celebrates its' 10-year anniversary in 2022 and events have been planned to mark this occasion. HART continues to provide the

Trust's specialist response to incidents involving chemicals, limited access and egress and incidents at height. Work is continuing to update the HART Incident Ground Technology and this work will continue over the coming months.

Prolonged Period in High Escalation (REAP levels)

The aim of the Resource Escalation Action Plan (REAP) is to describe the arrangements to be considered by the Trust in response to a strategic or dynamic assessment of pressures affecting or likely to affect service delivery. The categorisation is considered weekly at the Operations Weekly Demand, Capacity and Performance meeting which is attended by members of the Senior Leadership Team and others.

High levels of REAP were not really intended for prolonged periods of time, mainly because the actions within REAP are intended to help the Trust recover the situation. Throughout the period of the pandemic, and the current high pressures, the actions either within REAP, or other actions taken like cohorting areas, are not resulting in an ability to de-escalate.

An absolute application of the REAP actions for prolonged periods of time is highly likely to have medium to long term impacts on our capacity to transform, on regulatory requirements, and management and clinical supervision activity.

The Executive Management Team have therefore agreed that after a period of REAP 4 extending for two weeks, that the Strategic commander in consultation with the respective Director, balance the application of REAP 4 actions between the immediate needs of the presenting operational and clinical situation, versus the medium to long term impacts on transformation, regulatory requirements and management and clinical functions. At CSP 4a in REAP 4, it has also been agreed that all available clinical staff are expected to support patient facing duties.

Volunteering

In the first week of June, we celebrated our amazing workforce of volunteers during National Volunteer Week. Several coordinated media releases shone a light on the work of our volunteers who continue to provide a dedicated response as Volunteer Car Drivers, or Community First Responders.

❖ EMERGENCY MEDICAL SERVICE (EMS)

EMS Roster Review

The purpose of the EMS Roster Review project is to: deliver EMS Response rosters for Cymru High Acuity Response Unit (CHARU) replacing Rapid Response Vehicles (RRV), Emergency Ambulance (EA) and Urgent Care Service (UCS) aligned to patient demand; improve staff well-being and achieve an efficiency gain (not saving) of 72 FTEs, by December 2024.

Voting on the EMS Roster Review closed on Friday 20th May 2022. The project team have been working over the past few weeks to ratify the results, which is now complete. Whilst

the results of the vote have been shared with all staff an additional validation process is being confirmed with our trade unions. An implementation plan has been agreed at Project Board, which is scheduled to commence with Emergency Ambulance rosters in Hywel Dda from 5th September. A separate implementation plan for UCS and CHARU will be agreed in due course.

The project remains on track to be completed by the end of Q4 2023.

❖ RESOURCING & EMS COORDINATION

On 30th June 2022 the Senior Leadership Team approved the Standard Operating Procedure (SOP) for Remote Supervision. The purpose of the SOP is to allow remote supervision of Emergency Medical Dispatchers. Supervision is provided for EMDs in order to provide support for call handling performance, complex call management and clinical support for call escalation. This will also provide the opportunity for a remote call audit function, which will enhance our ability to carry out live call audit and will support the ongoing improvement in quality of the call handling service we offer communities across Wales. In addition, this facility will also support the ability for Clinicians through the Clinical Support Desk to directly listen in to calls, which will support the provision of timely clinical support when needed.

Following a period of stasis over the winter period, the EMS Coordination Reconfiguration Project Board resumed on 23rd May 2022. Project Board Members, which includes Trade Union Partners agreed to focus on the areas within the Project that can be progressed over the forthcoming months that will improve the delivery of services within the Centre and will focus on a review of the demand and capacity across the Centres, a roster review within the Department, the allocation of work across boundaries, and other opportunities for continuous improvement. This will report through the Operational Transformation Programme Board.

A Global Rostering System (GRS) Steering Group will shortly be set up to review the functionality available through the GRS Rostering System. Due to the onset of Covid many aspects of functionality available through the Rostering System were not implemented and additional functionality is now available to the Trust that would significantly improve the way we manage functions such as Continuous Professional Development, Timesheets and Annual leave. There are several system improvements that could prove incredibly useful to the organisation and staff alike and would help move us to a position where staff members are able to carry out a number of functions themselves. It is hoped that this Steering Group will help shape not only the current use of the GRS system but would also shape further development to the system to realise greater opportunities for working in a more efficient way.

❖ AMBULANCE CARE

Capacity Management Plan

Since the Capacity Management Plan has been deployed to try to control the Trust's spend on taxi usage, we have seen a reduction in expenditure. Further work is required to fully understand the impacts of using the Capacity Management Plan but financially this is aiding cost containment.

NEPTS Cleric Upgrade

Following completion of the new externally hosted environment for the upgraded NEPTS Computer Aided Dispatch (CAD), the new system is on schedule to go live in August 2022.

Transfer of UCS to Ambulance Care

The transfer of the urgent care service (UCS) to the Ambulance Care section took place on the 1st July. Early indications are that the transfer has occurred as expected, focus will now be placed upon integrating the service into the Ambulance Care function and refocusing the service towards delivering its' core purpose.

NEPTS Plurality Model Redesign

The first phase of the redesign of the NEPTS plurality model continues with tenders out for all externally commissioned work, this time using the new 3Q quality approach to measure both quality and value.

The new plurality model should improve value for money whilst also ensuring that we utilise providers of the highest quality. The new contracts will start to go live from the 1st October 2022.

❖ INTEGRATED CARE

111 Press 2

111 Press 2 went live in the Hywel Dda Health Board area on the 20th June. The service, operated by the Health Board in collaboration with WAST connects callers requiring urgent mental health support to a specialist practitioner. Further roll outs of the service are expected through the summer. We are closely monitoring any unanswered demand which returns to 111 core service. The early analysis indicates small numbers during the hours the service is non-operational.

111 Rostering

Following a significant staff engagement exercise the 111 Operations team have been working with Trade Unions, Resourcing and Staff to improve our approach to resourcing.

During July trials of new shift lengths and shift start times will commence pan-Wales. It's expected that these trials will improve our people's working lives and improve the alignment between 111 demand and capacity.

Further trials of fixed rosters are being developed to be in place later this summer.



AGENDA ITEM No	7
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

FINANCIAL SUSTAINABILITY WORKSTREAMS

MEETING	Finance and Performance Committee
DATE	18 th July 2022
EXECUTIVE	Chris Turley (Executive Director of Finance & Corporate Resources)
AUTHORS	Navin Kalia (Deputy Director of Finance & Corporate Resources)
CONTACT	Chris.Turley2@wales.nhs.uk

EXECUTIVE SUMMARY

- The Welsh Ambulance Services Trust (WAST) is required to produce a robust and balanced financial plan, underpinned by a savings and efficiency plan, a key deliverable of the Integrated Medium-Term Plan (IMTP).
- With this objective in mind, and given the financial outlook particularly beyond the current financial year, WAST has set off on a journey to produce its future savings plan on a more sustainable footing with a likely requirement of this needing to be at a scale greater than has been the case in the recent past. This will mean that more normal saving opportunities, often described as “the low hanging fruit” savings or “salami slicing” of existing budgets, cannot be continued to be relied upon to deliver a financially balanced outturn.
- To support delivery of a transformative financially sustainable savings programme, four Financial Sustainability Workstreams (FSW) have been set up covering the topics of Benchmarking Value, Achieving Efficiency, Income Generation and Best Practice. These will report, as a separate programme of work, into STB.
- This paper (with the aid of the attached appendix) sets out the purpose, scope, governance, membership, and reporting of the Financial Sustainability Workstreams (FSW).

KEY ISSUES/IMPLICATIONS

- Structure being put in place at WAST to ensure a transformative financially sustainable savings programme is produced to seek to help mitigate the challenging financial landscape WAST will need to navigate now and into the future.

REPORT APPROVAL ROUTE

- Finance and Performance Committee – 18th July 2022

REPORT APPENDICES

Annex 1 – Financial Sustainability Workstreams Terms of Reference

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	YES
Environmental/Sustainability	NA	Legal Implications	YES
Estate	NA	Patient Safety/Safeguarding	YES
Ethical Matters	NA	Risks (Inc. Reputational)	YES
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	YES

**WELSH AMBULANCE SERVICES NHS TRUST
FINANCE AND PERFORMANCE COMMITTEE**

FINANCIAL SUSTAINABILITY WORKSTREAMS

INTRODUCTION

1. WAST has produced small financial surpluses for a number of years, which has been unique in the historical financial climate – however the future financial funding levels for the public sector are expected to be significantly reduced. Therefore, a change in strategy is required to pursue more significant longer term financial value savings and efficiencies and to allow WAST to rapidly prepare and adapt to a financial and operating environment that will be far more challenging than WAST or indeed the entire NHS has potentially ever faced before.
2. To support the WAST strategy and delivery of a transformative financially sustainable savings programme, the Strategic Transformation Board (STB) in May 2022, agreed that four Financial Sustainability Workstreams (FSW) are set up covering the topics of Benchmarking Value, Achieving Efficiency, Income Generation and Best Practice.

BACKGROUND

3. The Welsh Ambulance Services Trust (WAST) is required to produce a robust and balanced financial plan, underpinned by a savings and efficiency plan, a key deliverable of the Integrated Medium-Term Plan (IMTP).
4. The need to produce a transformative savings plan is further underlined with WAST already having experienced in the past financial year the tightening of funding approvals from Commissioners and hence has increased the rating of Risk ID 139 on the Corporate Risk Register titled “Failure to deliver our Statutory Financial Duties in accordance with legislation”. Reduction in funding in the light of increasing patient demand will necessitate WAST in mitigation to increase its own savings value while delivering at pace and undoubtedly “self-fund” investment in services to enable continued resourcing at historic levels.

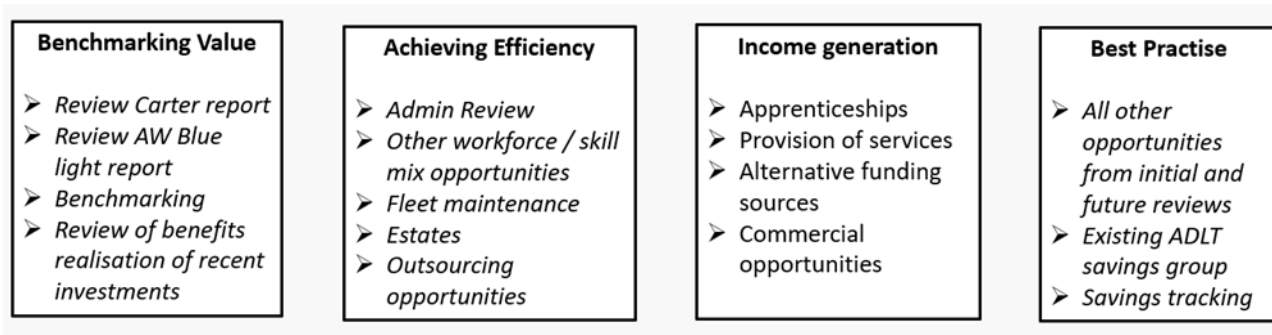
Purpose of Financial Sustainability Workstreams (FSW)

5. The purpose of each of the Financial Sustainability Workstreams (FSW) of Benchmarking Value, Achieving Efficiency, Income Generation and Best Practice is:
 - To work through in detail the specific savings ideas generated following a detailed joint ADLT / EMT Leadership discussion and series of workshops held in April 2022;
 - Generate effective individual savings schemes project plans with projected timelines and milestones identifying who is the lead on delivering the specific saving scheme and what are the key milestones and actions required to ensure delivery of the specific scheme;

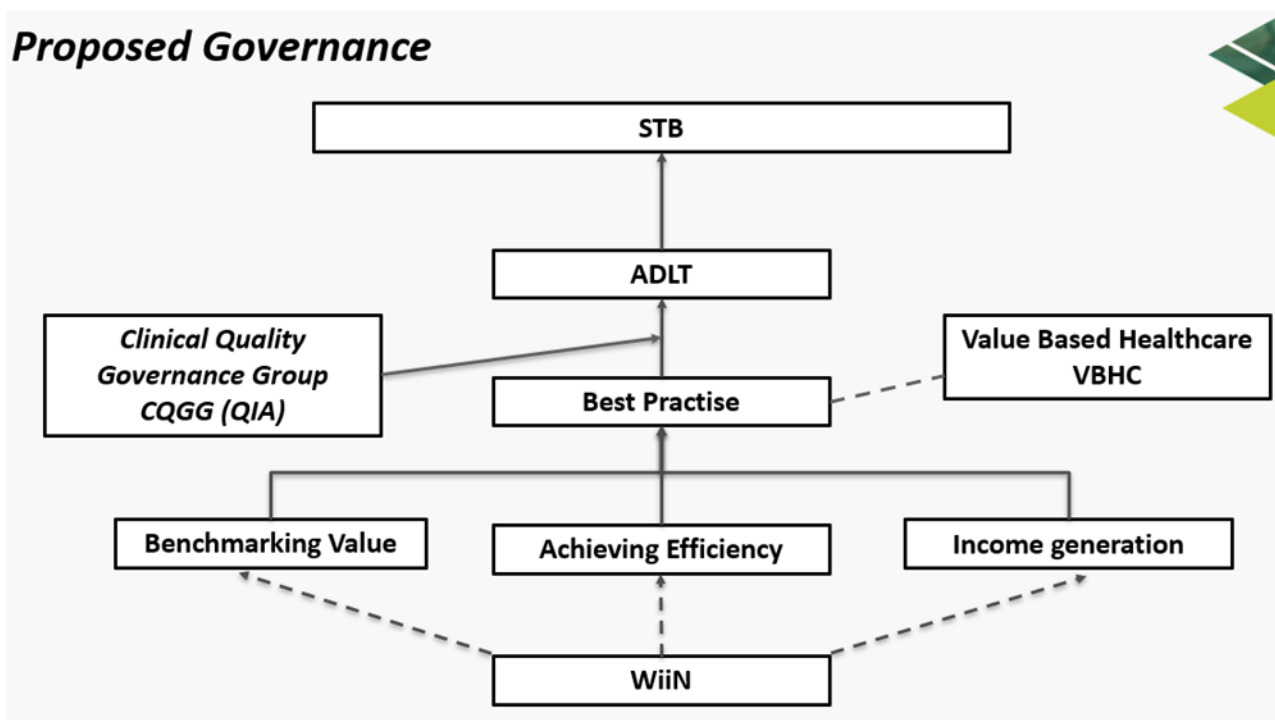
- To manage the flow of intelligence and information from across the organisation and externally to inform the savings plan;
 - To bring together operations, workforce, finance, revenue, and capital planning (estates, fleet and digital) as required to ensure appropriate ownership and delivery of a particular saving scheme with the relevant directorate.
6. The initial membership of each group is outlined in the attached appendix. Additionally, each group will also have a nominated Exec sponsor.

Governance

7. Figure 1 below outlines the FSW structure and the areas of focus (but are not limited to) for the Four Financial Sustainability Workstreams.



The overall Governance structure for the savings program is provided in figure 2 below.



8. It is proposed for The Clinical Quality Governance Group (CQGG) to provide Quality Impact Assessments (QIA) oversight of all savings the FSW decides to pursue, so that all savings and efficiencies that are planned to be delivered maintain or enhance quality of service to WAST patients.
9. The WAST Improvement & Innovation Network Sub-Group (WIIN) via its own work on efficiency and service improvement may feed in with a degree of its own identified cash releasing working schemes into the FSWs.
10. WAST has also set up the Value Based Health Care (VBHC) group which may provide some overlap in output with the FSWs and it will be beneficial to keep the VBHC group abreast of the work of the FSWs and vice versa.
11. If a scheme approved by the FSWs has a staffing implication, the actual delivery of that particular scheme will not be pursued until consultation has taken place with Trade Union partners via the TU cell meeting. Frequency of attendance by a FSW rep to the TU cell will depend on the frequency of schemes that have a staffing implication.

Reporting

12. All viable individual savings schemes agreed by the FSW to be delivered, must have progress monitored via the Individual Savings and Efficiency Progress Report template provided on the following page (see figure 3 page 6).
13. The Programme/project management support along with the Finance team, will need to play a key role in ensuring all details within the template below are captured correctly and in a timely manner.
14. In order to provide a high-level summary report of year-to-date progress in delivery of the saving schemes to ADLT, EMT and the Finance and Performance Committee; the Programme/project management support and the Finance team will need to ensure that the Savings and Efficiency Highlight Report (provided as an example at figure 4, page 7) is fully completed and again kept up to date in a timely manner.

Figure 3 Individual Savings and Efficiency Progress Report

Title / Theme		
Overview:	2022/23 target	
	£k	
Description		
Project Lead		
Senior Finance lead		

Narrative - What progress has been made in delivery of savings?			
Current Month :		Year to date / Risks :	
Assessment / Risk of Delivery (RAG)			
Current month	R	Year to date	A

Current performance:

Year to date target £		Year to Date delivery £		Year to date Variance £ under/over delivery	
£k		£k		£k	
% of total:	%	% of total:	%	%of target:	%

£000,s	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Target												
Delivered												
Variance												

Specific actions in place to deliver savings:

Action	Timeframes	Progress	Outcome	Assessment (RAG)
				G
				A
				G
				A
				G

Figure 4

Welsh Ambulance Services NHS Trust
Savings and Efficiency Highlight Report X 202X – X 202X

Financial performance overview:								Narrative (to Sept 19) - key Areas of:			
Title / Theme	Annex*	Lead	Annual Target £000s	YTD Target £000s	YTD Delivery £000s	YTD Variance £000s		Assessment of delivery (RAG)	Progress	Issues/risks (Operational & Financial)	Actions
Estates	a	XX	100	50	50	0		G	Savings on utilities / maintenance	New premises occupied in 21/22 so full year operating costs are not yet known. No operational delivery impact	Review extent of potential additional savings
Fleet	b	XX	200	100	30	-70		R	In month savings not achieved over a period of time due to pressures on fleet maintenance. The Trust volume of fuel purchased in the last quarter was broadly similar at the discounted sites Pressures on maintenance labour rates charged by contracted out garages.	Variability of fuel prices. Uncertainty of Brexit and impact on pricing.	Continued increase usage of fuel discount cards. Fuel reporting and accountability devolved to localities
Total			300	150	80	-70		R			

*Details of each scheme are attached at annexes a-b. (only referred to here as an example)

RECOMMENDED that the Committee:

15. **Notes** the establishment of the FSWs as detailed in this summary report and detailed points within the attached Terms of Reference for the Financial Sustainability Workstreams.



Welsh Ambulance Service NHS Trust Financial Sustainability Workstreams Terms of Reference

Author	Navin Kalia, Deputy Director of Finance & Corporate Resources		
Status	Final	Version	V 1.3
Date Created	June 2022		
Date Reviewed			
Version approved date	13 th June 2022 ADLT 27 th June 2022 STB		
Date of next Review	June 2023		

1. Context & Background

In line with all NHS organisations, the Welsh Ambulance Services Trust (WAST) is required to produce a robust and balanced financial plan, underpinned by a savings and efficiency plan, a key deliverable of the Integrated Medium-Term Plan (IMTP).

As we emerge from the pandemic, the NHS and UK Governments future direction of travel is to agree multi-year NHS financial settlements as opposed to the current annual yearly budgets. Hence the need to have transformational financially sustainable savings plans becomes ever more important if WAST is to deliver high quality and safe services to our patients as efficiently as possible to protect the investment of the taxpayer over multiple years.

The need to produce a transformative savings plan is further underlined with WAST already having experienced in the past financial year the tightening of funding approvals from Commissioners and hence has included Risk ID 139 on the Corporate Risk Register titled "Failure to deliver our Statutory Financial Duties in accordance with legislation". Reduction in funding in the light of increasing patient demand will necessitate WAST in mitigation to increase its own savings value while delivering at pace and self-fund investment in services to enable continued resourcing at historic levels.

With these aims in mind, WAST has set off on a journey to produce its future savings plan on a more sustainable footing and at scale as the normal saving opportunities, often described as the low hanging fruit savings or salami slicing of existing budgets, cannot be continued to be relied upon to deliver a financially balanced outturn.

It must be noted, WAST has produced financial surpluses for a number of years, which has been unique in the historical financial climate – however the future financial funding levels for the public sector are expected to be significantly reduced, therefore the change in strategy by WAST to pursue more significant longer term financial value savings and efficiencies is required to allow WAST to rapidly prepare and adapt to a financial and operating environment that will be far more challenging than WAST or indeed the entire NHS has ever faced before.

To support the WAST strategy and delivery of a transformative financially sustainable savings program, the Strategic Transformation Board in May 2022, agreed that four Financial Sustainability Workstreams (FSW) are set up covering the topics of Benchmarking Value, Achieving Efficiency, Income Generation and Best Practise.

These particular themes were the result of senior leadership conversations following the strategic savings identification discussions held at a ADLT & EMT joint meeting in April 2022.

These Terms of Reference therefore set out the purpose, scope, governance, membership, and reporting of the Financial Sustainability Workstreams (FSW).

2. Purpose

The purpose of each of the Financial Sustainability Workstreams (FSW) of Benchmarking Value, Achieving Efficiency, Income Generation and Best Practise is:

1. To work through in detail the specific savings ideas generated following the ADLT EMT Leadership discussion.
2. Generate effective individual savings schemes project plans with projected timelines and milestones identifying who is the lead on delivering the specific saving scheme and what are the key milestones and actions required to ensure delivery of the specific scheme.
3. To manage the flow of intelligence and information from across the organisation and externally to inform the savings plan.
4. To bring together operations, workforce, finance, revenue, and capital planning (estates, fleet and digital) as required to ensure appropriate ownership and delivery of a particular saving scheme with the relevant directorate.

3. Scope and duties

The following is considered in scope:

i. Managing the flow of intelligence

The FSW will keep ALDT, STB & EMT appraised regarding service change proposed by the FSW by developing and maintaining a robust approach to tracking and evaluating such changes. In doing so it will:

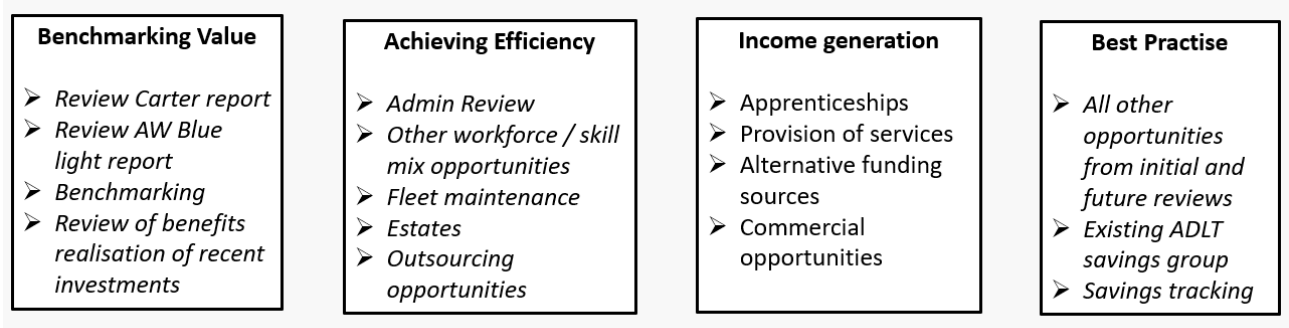
- Ensure the proposed changes are clearly understood and known across the organisation.
- Direct activities from within WAST that will aid the understanding of the implications for WAST, e.g., activity modelling.
- Lead on the preparation of any project initiation documents (PID), business cases or similar documentation that articulates the implications of these changes, including where there is a need for the change to be commissioned or decommissioned.
- Ensure topics on which savings are pursued have a strategic fit to the Trust's IMTP.
- Consider the implications of improvements developed through WIIN to inform IMTP and strategic planning.
- Also please refer to the Reporting section of this paper found on page 7.

ii. Revenue & Capital Forecasting & Planning implications

The FSW will consider the revenue and capital implications of the information received and discussed at the meeting to inform the ongoing review of the Trust's revenue and capital plans across pay, non-pay, estates, digital and fleet. This is not to replace or duplicate existing structures but how we use intelligence to inform existing structures to undertake their business roles.

4. Governance

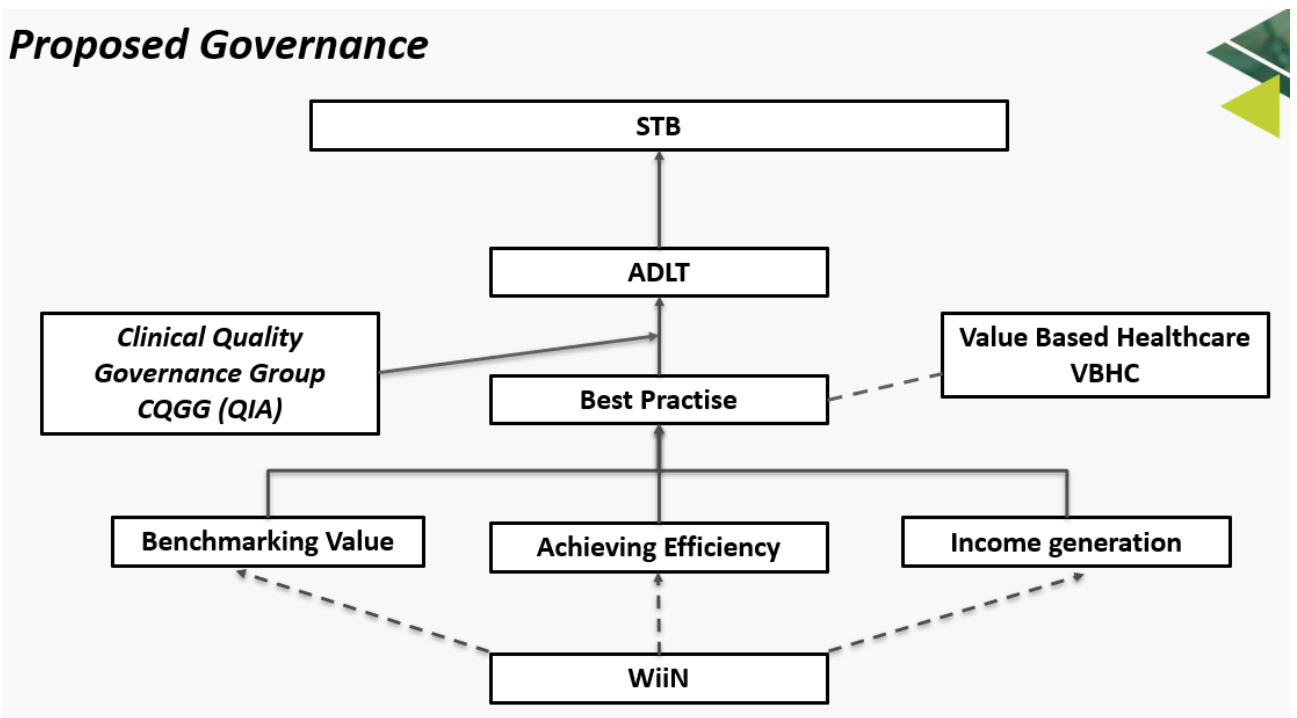
Figure 1 below outlines the FSW structure and the areas of focus (but are not limited to) for the Four Financial Sustainability Workstreams.



The Best Practise FSW (via the Deputy Director of Finance & Corporate Services) shall report to the Assistant Director Leadership Team (ADLT) on a quarterly basis with STB also supporting the ongoing development of its forward work programme to consider planning and delivery issues.

At its discretion ADLT, STB, EMT or the Finance & Performance Committee may commission further specific work from the FSW as well as prioritisation of certain subjects.

The overall Governance structure for the savings program is provided in figure 2 below.



It is proposed for The Clinical Quality Governance Group (CQGG) to provide Quality Impact Assessments (QIA) oversight of all savings the FSW decides to pursue, so that all savings and efficiencies that are planned to be delivered maintain or enhance quality of service to WAST patients.

The WAST Improvement & Innovation Network Sub-Group (WIIN) via its own work on efficiency and service improvement may feed in with a degree of its own identified cash releasing working schemes into the FSWs.

WAST has also set up the Value Based Health Care (VBHC) group which may provide some overlap in output with the FSWs and it will be beneficial to keep the VBHC group abreast of the work of the FSWs and vice versa.

If a scheme approved by the FSWs has a staffing implication, the actual delivery of that particular scheme will not be pursued until consultation has taken place with Trade Union partners via the TU cell meeting. Frequency of attendance by a FSW rep to the TU cell will depend on the frequency of schemes that have a staffing implication.

5. Membership, quorum, and meetings

Membership for the four Financial Sustainability Workstreams (FSW) shall be:

- i) Income Generation Financial Sustainability Workstream:
 - Deputy Director of Finance & Corporate Services (Chair)
 - Deputy Head of Financial Accounting
 - Assistant Director of Operations NEPTS
 - Head of Service – EPRR and Specialist Operations
 - Head of Education Transformation
 - Interim Head of Strategy & Development
 - Regional Fleet Manager
 - Programme/project management support
 - Secretariat support

- ii) Benchmarking Value Financial Sustainability Workstream:
 - Head of Financial Business Intelligence & Capital Planning (Chair)
 - Senior Finance Business Partner
 - Assistant Director of Operations
 - Assistant Director, Commissioning & Performance
 - Assistant Director for Data and Analytics Digital
 - Head of Capital Development
 - Programme/project management support
 - Secretariat support

- iii) Achieving Efficiency Financial Sustainability Workstream:
 - Head of Financial Business Intelligence & Capital Planning (Chair)
 - Senior Finance Business Partner x2
 - Assistant Director of Operations, Resourcing & EMS Coordination
 - Assistant Director of Capital & Estates
 - Head of People Services
 - National Fleet Manager
 - Programme/project management support
 - Secretariat support

- iv) *Best Practise Financial Sustainability Workstream:
 - Head of Financial Management (Chair)
 - Senior Finance Business Partner x2
 - Assistant Director of Operations, National Operations & Support
 - Assistant Director of Planning and Transformation
 - Interim Assistant Director Research, Audit & Service Improvement
 - Deputy Director of Workforce & OD
 - Head of ICT
 - Programme/project management support
 - Secretariat support

*Chairs of Income Generation (Deputy Director of Finance and Corporate Services) and Benchmarking Value, Achieving Efficiency (Head of Financial Business Intelligence & Capital Planning) Financial Sustainability Workstreams to attend the Best Practise Workstream on a quarterly basis to report progress of savings workstreams allow savings tracking & consolidation overall. A member of the Quality, Safety & Patient Experience Directorate, will also attend to provide oversight of the safety of savings schemes to be delivered.

Other members may be co-opted or attend ad hoc as necessary. The meeting shall be quorate (if required) when the chair (or nominated deputy), and key disciplines are present. Where a required attendee cannot attend, a nominated deputy must be present.

Programme/project management support will be provided by the Planning and Performance Directorate and Secretariat support will be provided by the Finance and Corporate Services Directorate.

Meetings will take place once a month. Each meeting will be scheduled for 1.5 hours with the aim of concluding business as soon as possible.

As noted earlier in this paper, one meeting per quarter of the Best Practise FSW will be used for all four FSWs to provide an update on progress and feed into a consolidated savings tracker.

Each FSW will have an individual Executive sponsor.
 The SRO for the overall program is the Director of Finance & Corporate Services.

6. Reporting

All viable individual savings schemes agreed by the FSW to be delivered, must have progress monitored via the Individual Savings and Efficiency Progress Report template provided on the following page (see figure 3 page 7).

The Programme/project management support along with the Finance team, will need to play a key role in ensuring all details within the template below are captured correctly and in a timely manner.

In order to provide a high-level summary report of year-to-date progress in delivery of the saving schemes to ADLT, EMT and the Finance and Performance Committee; the Programme/project management support and the Finance team will need to ensure that the Savings and Efficiency Highlight Report (provided as an example at figure 4, page 9) is fully completed and again kept up to date in a timely manner.

Figure 3 Individual Savings and Efficiency Progress Report

Title / Theme		
Overview:	2022/23 target	
	£k	
Description		
Project Lead		
Senior Finance lead		

Narrative - What progress has been made in delivery of savings?			
Current Month :		Year to date / Risks :	
Assessment / Risk of Delivery (RAG)			
Current month	R	Year to date	A

Current performance:

Year to date target £	Year to Date delivery £	Year to date Variance £ under/over delivery

£k		£k		£k	
% of total:	%	% of total:	%	%of target:	%

£000,s	Quarter 1			Quarter 2			Quarter 3			Quarter 4		
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Target												
Delivered												
Variance												

Specific actions in place to deliver savings:

Action	Timeframes	Progress	Outcome	Assessment (RAG)
				G
				A
				G
				A
				G

Figure 4

Welsh Ambulance Services NHS Trust
Savings and Efficiency Highlight Report X 202X – X 202X

Financial performance overview:								Narrative (to Sept 19) - key Areas of:		
Title / Theme	Annex*	Lead	Annual Target £000s	YTD Target £000s	YTD Delivery £000s	YTD Variance £000s	Assessment of delivery (RAG)	Progress	Issues/risks (Operational & Financial)	Actions
Estates	a	XX	100	50	50	0	G	Savings on utilities / maintenance	New premises occupied in 21/22 so full year operating costs are not yet known. No operational delivery impact	Review extent of potential additional savings
Fleet	b	XX	200	100	30	-70	R	In month savings not achieved over a period of time due to pressures on fleet maintenance. The Trust volume of fuel purchased in the last quarter was broadly similar at the discounted sites Pressures on maintenance labour rates charged by contracted out garages.	Variability of fuel prices. Uncertainty of Brexit and impact on pricing.	Continued increase usage of fuel discount cards. Fuel reporting and accountability devolved to localities
Total			300	150	80	-70	R			

*Details of each scheme are attached at annexes a-b. (only referred to here as an example)



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	8
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	2

MONTHLY INTEGRATED QUALITY & PERFORMANCE DASHBOARD – May / June 2022

MEETING	Finance & Performance Committee
DATE	17 July-22
EXECUTIVE	Rachel Marsh – Director of Strategy, Planning and Performance
AUTHOR	Hugh Bennett – Assistant Director of Commissioning and Performance Nicola Quiller – Commissioning & Performance Officer
CONTACT	Hugh.bennett2@wales.nhs.uk Nicola.Quiller@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this report is to provide senior decision makers in the Trust with an integrated dashboard (Our Patients, Our People, Value and Partnerships/System Contribution) focused on the “vital few” key metrics. This report is for **May (and where available June) 2022**.

RECOMMENDATION

FPC is asked to:-

- **Consider** the May/June 2022 Integrated Quality and Performance Report and actions being taken and determine whether:
 - a) the report provides sufficient assurance;
 - b) whether further information, scrutiny or assurance is required, or
 - c) further remedial actions are to be undertaken through Executives.
- **Consider** the proposed new metrics and endorse or amend for onward approval to Board

KEY ISSUES/IMPLICATIONS

Overview

This Integrated Quality & Performance Report contains information on 28 key indicators at a highly summarised level which aims to demonstrate how the Trust is performing across four integrated areas of focus:

- Our Patients (Quality, Safety and Patient Experience);
- Our People;
- Finance and Value; and
- Partnerships and System Contribution.

These four areas of focus broadly correlate with the Quadruple aims set out in 'A Healthier Wales'.

As previously agreed, the metrics which form a part of this committee/Board report will be updated on an annual basis, to ensure that they continue to represent the best way of tracking progress against our plans (IMTP) and strategies. This annual review is complete with Appendix 1 including the proposed new set for consideration.

Our Patients – Quality, Safety and Patient Experience

Call answering (safety): The speed at which the Trust is able to answer a 999 or 111 call is a key patient safety measure.

999 answering times have been challenged through significant increases in demand. The median and 65th percentile performance remain good, the call answering tail remains at just over 20 seconds, which is higher than the Trust would want, but this is a significant improvement on previous months where it has been over one minute.

There is no additional funding secured into 2022/23 for 999 call handlers. Forecasting and modelling is being undertaken on the future call taker requirement through to December 2024, which is currently with the AD EMS Co-ordination & Resource for consideration.

111 call answering performance saw an improvement in May 2022 but then a deterioration in June. Recent negotiations with commissioners suggest that we have broadly the right number of call handlers in post, however, further work is required to reduce capacity lost through sickness absence, align capacity with demand through a roster review and improve efficiency of use of resource. A recent demand & capacity review of 111 by Operational Research in Health (ORH) will be presented formally to EMT in the next few weeks.

111 Clinical response: whilst the Trust continues to see achievement of the clinical call back times for the highest priority 111 calls, a decline in performance across all the priorities was seen in June 2022. The Trust knows that the waits for a clinical ring back are too long. Recruitment and retention of clinicians remains a priority, with significant numbers of clinical vacancies currently. Urgent discussions are underway to develop a more focused plan to increase clinician numbers.

Ambulance Response (safety / patient experience): Red and Amber response times declined into June 2022 and a marginal increase in patient demand was seen. The Amber 1 tail (95th percentile) remains at unacceptable levels, at six hours 48 minutes. These long response times have a direct impact on outcomes for many patients. Actions within the Trust's control include:

Capacity:

- Recruitment: the Trust has a revised relief gap of 148 FTEs for Ambulance Response which takes into account the uplift in FTEs required for the Cymru High Acuity Response Unit (CHARU), the decision not to reduce any emergency ambulance cover in Hywel Dda and prioritisation of CSD staffing increases. The Trust has recently received an additional £3m in 2022/23 which will allow the Trust to recruit 100 FTEs. Due to the length of training, the majority of these additional staff will become operational in Q4.
- Summer/winter modelling: the Trust has recently completed its summer modelling and is in the process of sharing the results with senior stakeholders across the system. The Trust will seek to bring forward potential tactical actions it can take through the summer and winter that put further capacity into the system (the winter modelling is expected to be completed no later than mid-August 2022). This demonstrates a continued level of very poor response times.

Efficiency (rosters, abstractions/sickness absence and post production lost hours):

- The Ambulance Response roster review is on target for go live between September 2022 and November 2022. This will have the equivalent performance impact of 72 FTEs.
- A Managing Attendance Programme has been agreed with EMT, which includes seven work-streams. This is now live and being reported to EMT every two weeks. This is planned to reduce sickness absence in line with a trajectory included in the IMTP.
- Further discussion continues constructively with trade union partners on a range of other potential workforce efficiencies and staff-well-being.

Demand Management

- The Trust has prioritised 41 additional clinicians into the Clinical Support Desk, with 36 Paramedic FTEs and five mental health practitioners successfully recruited and now in place. As well as improving the safety of the calls that are waiting, this investment will also mean an increase in consult and close rates, with the Trust now aiming to achieve a 15% rate for the second half of 2022/23, an increase in the previous target of 10.2% which has been delivered. The Clinical Support Desk has made good progress and currently has a 6% vacancy level against the new establishment of 96 FTEs.

One of the key factors in relation to response times is the capacity lost to handover outside Emergency Departments. There were over 23,000 hours lost in June 2022, which represents 30% of the total number of conveying resource hours produced for the month. The levels are so extreme that all the actions within the Trust's control cannot mitigate and offset this level of loss. Urgent and high level discussions have taken place between the Trust, Health Board CEOs and the CEO of NHS Wales. A number of mitigating actions have been agreed, and a target of no >4 hour waits and

a reduction of 25% in total lost hours (from Oct. 21 baseline). Delivery against these commitments will be monitored through this performance report in future months.

Ambulance Care (formally NEPTS) (Patient Experience): performance was above target for enhanced renal patient arrivals prior to appointment in June 2022 and has improved for patients requiring discharge; however, overall demand for the service continues to increase, although it has not yet recovered to pre CoVID-19 levels. EASC (10th May 2022) had a “focus on” development session on NEPTS, which included looking at the imbalance of demand and capacity and options for resolving this. Other areas of focus include: call answering performance, with a performance recovery plan in place, and oncology. Oncology may require a change in performance standard as the NEPTS Demand & Capacity Review identified that achieving the current standard through increasing FTEs would be prohibitively expensive. A project initiation document for improving performance and patient experience for oncology has been drafted and is now awaiting final approval by the Ambulance Care Transformation Programme Board. The feedback from the “focus on” session with EASC indicated a need to look at NEPTS changing demand and the capacity to support this. In the short term a capacity management plan is in place whilst pre-work is being undertaken on a potential roster review next year. A more efficient management of demand is another line of enquiry.

National Reportable Incidents (NRIs) / Concerns Response: the Trust reported 3 NRIs to the Delivery Unit in June 2022, compared to 11 in May 2022; and 24 serious patient safety incidents were referred to health boards in June 2022 under the “Appendix B” arrangement, compared to 7 in May 2022. In May 2022 complaint response times declined to 41% therefore failing to meet the 75% target. In the main, many of these incidents will be as a result of continued longer response times and the actions outlined below therefore are key.

Our People (workforce resourcing, experience and safety)

Hours Produced: 117,865 Ambulance Response ambulance unit hours were produced in June 2022. The emergency ambulance unit hours production (UHP) was 93% in June 2022 and RRV UHP was 79%. Key to the hours produced is the abstractions which remain high.

Response Abstractions: abstraction levels increased marginally in June 2022 to 38%, but are significantly improved from the high in March 2022 of 49%, however, they remain much higher than the 30% benchmark. COVID-19 has had a significant impact on abstractions with sickness abstractions being 10% in June 2022 (benchmark 5.99%). Workforce fatigue is also an issue.

Trust Sickness absence: The Trust’s overall sickness percentage (April 2022) was 11.14% and high sickness levels were seen across all areas of the Trust’s operations including Ambulance Response, EMS Co-ordination, 111 and Ambulance Care, affecting capacity in all areas. Actions within the IMTP concentrate on staff well-being with an aim to start to reduce this level. In addition, Employee Assistance Provider (EAP) data suggests that most requests for counselling are as a result of work related stress. A specific Managing Attendance programme has been established, led by the Deputy Director of WOD, to identify and implement actions across a range of areas to improve sickness absence and alternative duties.

Staff training and PADRs: Stat / Mand training compliance rates have been improving and hit the target of 85% for the first time in nearly 2 years. PADR levels remain low.

Finance and Value

Financial Balance: The Trust has reported outturn performance for May 2022 with a surplus of £4,000 and has a forecast to the year-end of breakeven. At present the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit for 2022/23.

Post-production lost hours: The efficient and effective use of the capacity that the Trust produces is a key indicator. This is measured within the EMS service by the calculation of post-production lost hours (PPLHs). The reasons for PPLHs are many and varied. The EMS Demand & Capacity Review identified that the Trust benchmarked favourably on all elements of PPLH other than return to base meal breaks. The Trust and TU partners continue to work together on options for change. Modelling indicates that the efficiency gain in PPLH is very small in comparison to the impact of handover lost hours.

Partnerships/ System Contribution

Shift left: much of Trust's work relates to working with health boards and other partners to provide the right care closer to home and reducing the number of patients who need to be conveyed to hospital. Good progress has been made through the year in increasing **consult and close** rates after 999 calls; and the Trust achieved 12.2% in May 2022, compared to the benchmark of 10.2%, which was exceeded during 2021/22.

The Trust has an ambition to shift more patient demand left, where it is clinically safe to do so through both consult and close and see & treat, a position consistent with the EMS commissioning framework. To this end the Trust has increased the establishment in the Clinical Support Desk by 41 FTEs, almost doubling the existing establishment, with 36 Paramedic FTEs and a 5 mental health professionals FTEs into the Clinical Support Desk (CSD). The Trust is also implementing new clinical triage software (now live) and working with health boards on how they can support remote demand management. There is a revised ambition of 15% for consult and close into 2022/23 (for the second half of the year).

The Trust **conveyed** 39% of patients to emergency departments in May 2022, but this figure needs to be treated with significant caution as analysis shows that conveyance rates are linked to pressures within the system and the application of the Clinical Safety Plan (CSP), which will trigger the Trust being unable to send ambulances to lower acuity calls, with many patients cancelling the ambulance due to the long response times. In June, over 11,000 patients cancelled their ambulance and we were unable to send an ambulance due to application of CSP levels to nearly 1000 callers. In the longer term, as we know, we are clear that the system needs to transform if it is to become more sustainable. A formal programme to take forward "inverting the triangle" has been established. A bid as been submitted to Welsh Government to start to increase numbers of APPs being trained.

Handover lost hours: 23,387 hours were lost in June 2022. These levels are unprecedented and extreme and whilst the Trust can seek to mitigate the impact of handover lost hours through various efficiencies, the Trust cannot offset this scale of

lost hours. The Trust continues to raise this issue with EASC, Health Boards and Welsh Government. Fortnightly meetings have been established with each health board by the CASC, which WAST attends, which are designed to focus on action plans and trajectories for improvement. The 2022/23 EASC commissioning intentions for handover lost hours focuses on setting improvement trajectories per site; however, the pressure on the unscheduled care system as Wales emerges from the pandemic mean that the Trust can expect these extreme levels to continue into 2022. Ministerial direction indicates that the Immediate Release Directions should be accepted and an escalation procedure is being agreed nationally.

There have been a recent high profile report which references handover, the Health & Social Care Committee report on Hospital Discharge and its Impact on Patient Flow through Hospitals ([Hospital discharge and its impact on patient flow through hospitals \(senedd.wales\)](https://www.senedd.wales)), and includes recommendation six:-

“The Welsh Government should explain how the targets outlined in the Minister for Health and Social Service’s statement of 19 May 2022 on urgent and emergency care and the Six Goals Programme to eradicate ambulance patient handover delays of more than four hours and reduce the average ambulance time lost per arrival by 25 per cent (from the October 2021 level) have been set. It should also confirm the target dates for the achievement of these targets”.

Summary

The indicators used at this high-level show, in many areas, a continued poor picture in terms of the quality and safety of the service that the Trust provides to patients. Demand across the 111 and EMS services increased in June 2022, this coupled with other factors such as the continuation of the CoVID-19 variants, high levels of sickness (including CoVID-19 related absence) and extreme handover lost hours continue to impact on the Trust, in particular, the EMS. EASC, WG and the 111 Programme Board have been very supportive of the Trust through the pandemic, investing in a range of mitigations; however, funding for further initiatives is currently limited as the fiscal position becomes much tighter. For 111 and Ambulance Care (NEPTS) the Trust can look to take a range of actions to optimise the balance between patient demand and capacity; however for Ambulance Response the Trust cannot take sufficient actions within its control to mitigate the impact of the extreme handover lost hours. As a result all three committees have expressed serious concern about the impact of handover lost hours on patient safety and staff well-being. The Trust has just received further funding (£3m) for +100 FTEs into Ambulance Response, which is welcome, but it remains critical to patient safety that handover lost hours are reduced in line with Ministerial expectation.

REPORT APPROVAL ROUTE

Date	Meeting
11 July 2022	Assistant Director of Commissioning & Performance Director of Strategy Planning & Performance
13 July 2022	Executive Management Team
17 July 2022	Finance & Performance Committee

REPORT APPENDICES**Appendix 1 – Top Indicator Dashboard****REPORT CHECKLIST**

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	x	Financial Implications	x
Environmental/Sustainability	x	Legal Implications	x
Estate	x	Patient Safety/Safeguarding	x
Ethical Matters	x	Risks (Inc. Reputational)	x
Health Improvement	x	Socio Economic Duty	x
Health and Safety	x	TU Partner Consultation	x



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Welsh Ambulance Services
NHS Trust

Finance and Performance Committee

Review of Board level metrics July 2022





Current Metrics



Our Patients	111 call handling abandonment rate 111 clinical triage call back time (P1) 999 call handling time 95 th centile Red 8 minute Red 95 th centile Amber 1 95 th centile ROSC rates Stroke bundle compliance ACS bundle compliance NEPTS renal journey performance NEPTS Discharge performance Complaints response times NRIs (WAST)	Our People	EMS Abstractions Total EMS Hours produced Organisational sickness absence level Vaccination rates Statutory / Mand compliance PDR compliance EMS FTEs in post Other front line FTEs in post
		Value	Financial balance Utilisation metric EMS Post production lost hours EMS
		Partnerships / System Contribution	Consult and close (111) Hear and treat rates (999) Conveyance rates Hospital handover lost hours





Proposed Metrics

Our Patients

- 111 call handling abandonment rate
- 111 clinical triage call back time (P1)
- 999 call handling time 95th centile
- Red 8 minute
- **Red 95th centile**
- Amber 1 95th centile (? Mean?)
- ROSC rates
- **Stroke bundle compliance**
- **Call to Door Times STEMI/Stroke**
- **% stroke with direct admission to stroke unit within 4 hours**
- ACS bundle compliance
- NEPTS renal journey performance
- NEPTS Discharge performance
- Complaints response times
- NRIs (WAST)
- **Immediate release**
- **Numbers of no send / patient cancellation**
- **PREMs/ PROMS?**

Only need one key metric on red – take out

New indicators will replace this one
Commissioning intention – suggest use this one
Performance Framework – but one for HBs

Important new measure system has signed up to
Important new measure of harm
Nothing in current list which represents patient view –
agree to develop over the year





Proposed Metrics



Our People

Capacity

- Total EMS Hours produced against commissioned levels
- EMS FTEs in post
- EMS Abstractions
- Other hours produced against commissioned levels for 111
- Other front line FTEs in post

Health and Well-being

- Organisational sickness absence level
- Ops sickness absence
- Turnover rate
- Vaccination rates
- Statutory / Mand compliance
- PADR compliance

Equality / Inclusion

- TBD

These are all factors in production
These are factors in production
Suggest that this is as important as EMS

This is a factor in hours produced

Specific trajectory for this year for EMS
Suggested additional indicator of work experience

Important part of our IMTP – work to be done on which indicator is best





Proposed Metrics



Value	<ul style="list-style-type: none">• Financial balance• Utilisation metric EMS• Post production lost hours EMS• Numbers of jobs per shift / hour• Emissions	Need to identify a better descriptor Important measure of value in EMS In performance framework
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Proposed Metrics



<p>Partnerships / System Contribution</p>	<ul style="list-style-type: none">• Consult and close (111)• Consult and close rates (999)• Conveyance rate• See, treat and refer rate• Percentage of total conveyances taken to a service other than a Type One Emergency Department• Hospital handover lost hours• Number of patients over 4 hours wait• Numbers of completed symptom checkers	<p>Further work during year – what are we trying to achieve? Split by ambulance prevent / ED prevent Doesn't show what is really happening Inverting the triangle Performance Framework – and ITT</p> <p>Important new measure from EASC Ambition as part of 111 strategy</p>
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Welsh Ambulance Services
NHS Trust

Monthly Integrated Quality & Performance Report

May/June 2022

Annex 1 – Top Indicator Dashboard





Section 1: Monthly Indicators / Top Indicators Dashboard



Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	May-22	Jun-22	2 Year Trend	RAG	Top Monthly Indicators	Target 2022/23	Baseline Position (2021/22)	May-22	Jun-22	2 Year Trend	RAG
Our Patients - Quality, Safety and Patient Experience							Our People						
111 Abandoned Calls	< 5%	18.60%	5.4%	14.0%		R	EMS Abstraction Rate	29.92%	42.00%	38%	38%		R
111 Patients called back within 1 hour (P1)	90%	94.00%	94.6%	94.4%		G	Hours Produced for Emergency Ambulances	95%	95.0%	95%	93%		A
999 Call Answer Times 95th Percentile	95% in 00:00:05	00:52	00:22	-		A	Sickness Absence (all staff)	5.99%	10.48%	-	-		R
999 Red Response within 8 minutes	65%	55.2%	54.5%	50.8%		R	Frontline CoVID-19 Vaccination Rates	-	3913	4,283	-		-
Red 95th percentile	00:14:00	00:21:51	00:22:17	00:24:44		R	Statutory & Mandatory Training	>85%	82.3%	85.24%	-		G
999 Amber 1 95th percentile	01:18:00	04:52:34	04:34:15	06:48:40		R	PADR/Medical Appraisal	>85%	60%	56.05%	-		R
Return of Spontaneous Circulation (ROSC)	Improve	12.85%	-	-		G	Ambulance Response FTEs in Post	1700	1607	1634	-		A
Stroke Patients with Appropriate Care	95%	96.73%	79.80%	-		R	Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post	-	1568	1706	-		-
Acute Coronary Syndrome Patients with Appropriate Care	95%	78.55%	-	-		A	Value						
Renal journeys arriving within 30 minutes of their appointment (NEPTS)	70%	79%	77%	75%		G	Financial balance - annual expenditure YTD as % of budget expenditure YTD	100%	100%	100.00%	-		G
Discharge & Transfer journeys collected less than 60 minutes after booked time (NEPTS)	90%	81.00%	90%	87%		A	EMS Utilisation metric	57%	-	-	-		-
National Reportable Incidents reports (NRI)	Reduction Trend	5	11	3		A	Post-Production Lost Hours (EA, RRV, UCS)	Reduction Trend	-	5835:05:53	-		A
Concerns Response within 30 Days	75%	61%	41%	-		R	Partnerships / System Contribution						
							111 Consult and Close	Improve	7,843	15,819	17,208		G
							Combined 999 & 111 Hear & Treat	15.0%	10.4%	12.2%	-		G
							% Incidents Conveyed to Major EDs	<48.6%	35.99%	39.02%	-		G
							Number of Handover Lost Hours	< 150 hrs per day	15,955	22,080	23,387		R

In-Month RAG Indicators =
 Green: Performance is at or has exceeded the target (Indicates no action is required)
 Red: Performance is less than 10% of target (Indicates close monitoring or significant action is required)

Amber: Performance is at or within 10% of target (Indicates some issues/risks to performance (monitoring is required))
 TBD: Status cannot be calculated (To Be Determined)





COVID-19 Virus Monitoring



Wales Situation Report

Source: Welsh Government
Waste Water Monitoring Report extracted 01/07/2022

Since the last report, SARS-CoV-2 viral load has decreased across the country.

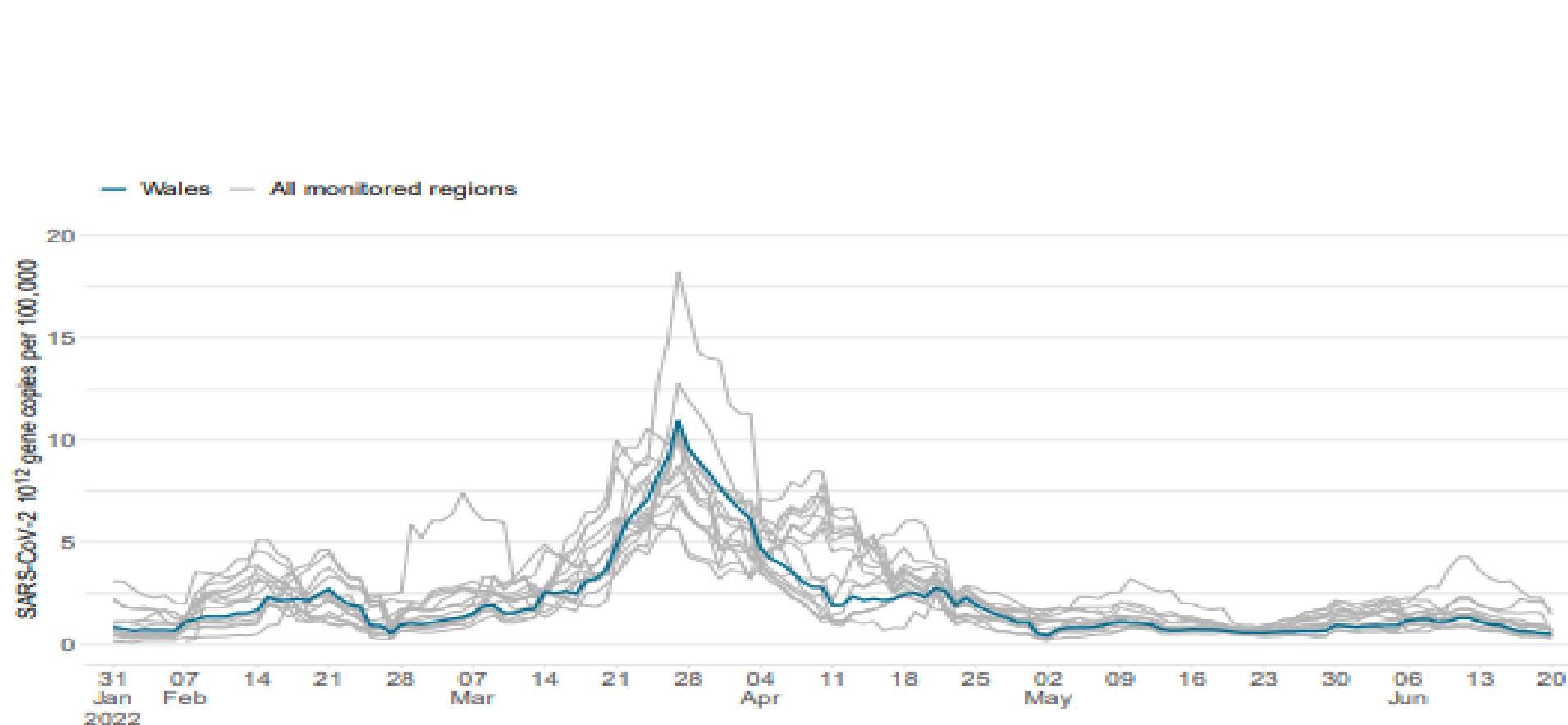


Figure 2 - National (blue lines) and Regions (grey lines) Rolling Mean SARS-CoV-2 gc/day per 100k

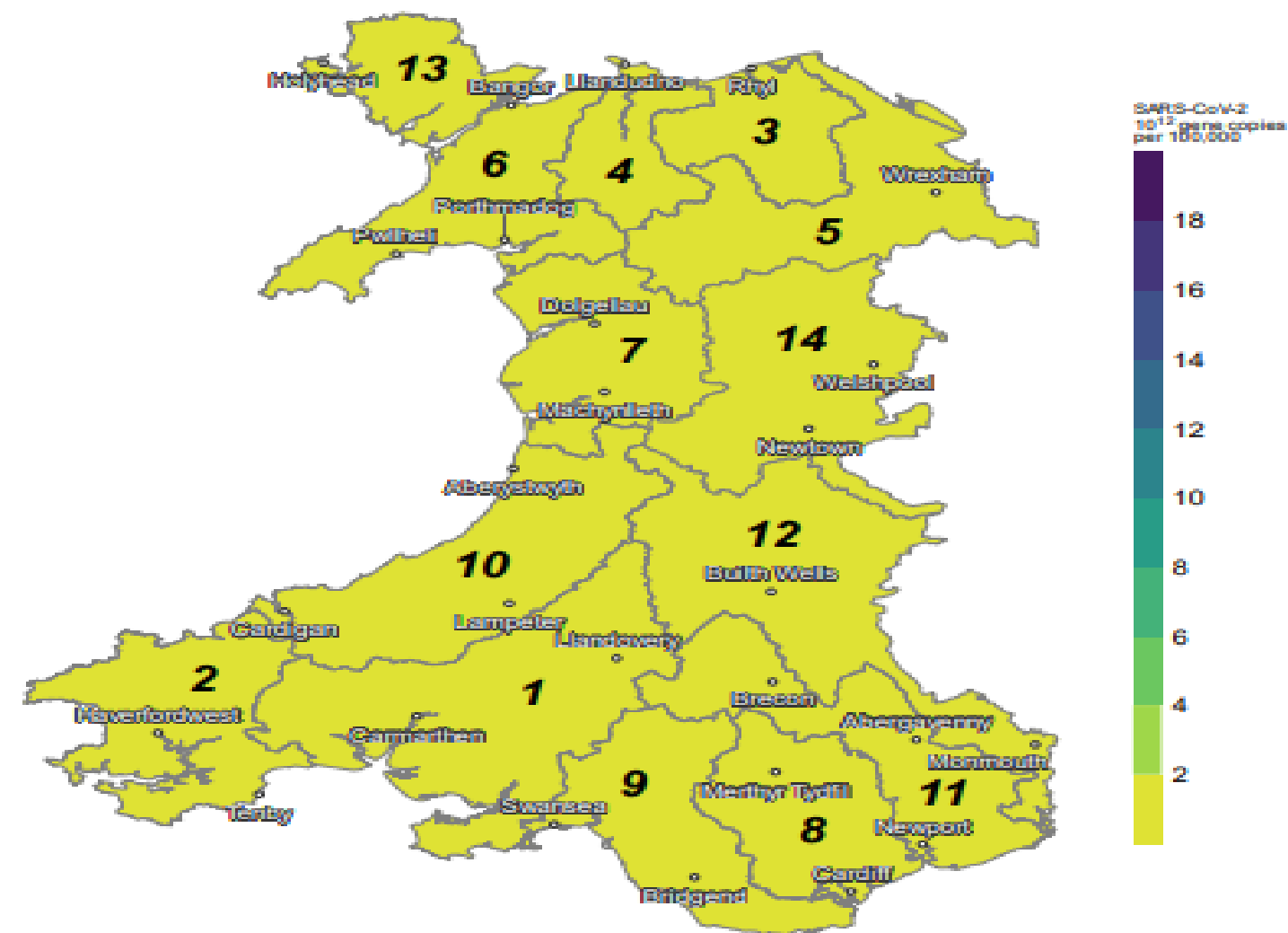


Figure 3 - National Heat Map showing Regional Mean SARS-CoV-2 gc/day per 100k

Data Source: Welsh Government: Wastewater Monitoring in Wales. Publication Date: 23/06/2022



(Responsible Officer: Rachel Marsh)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Patient Safety & Experience

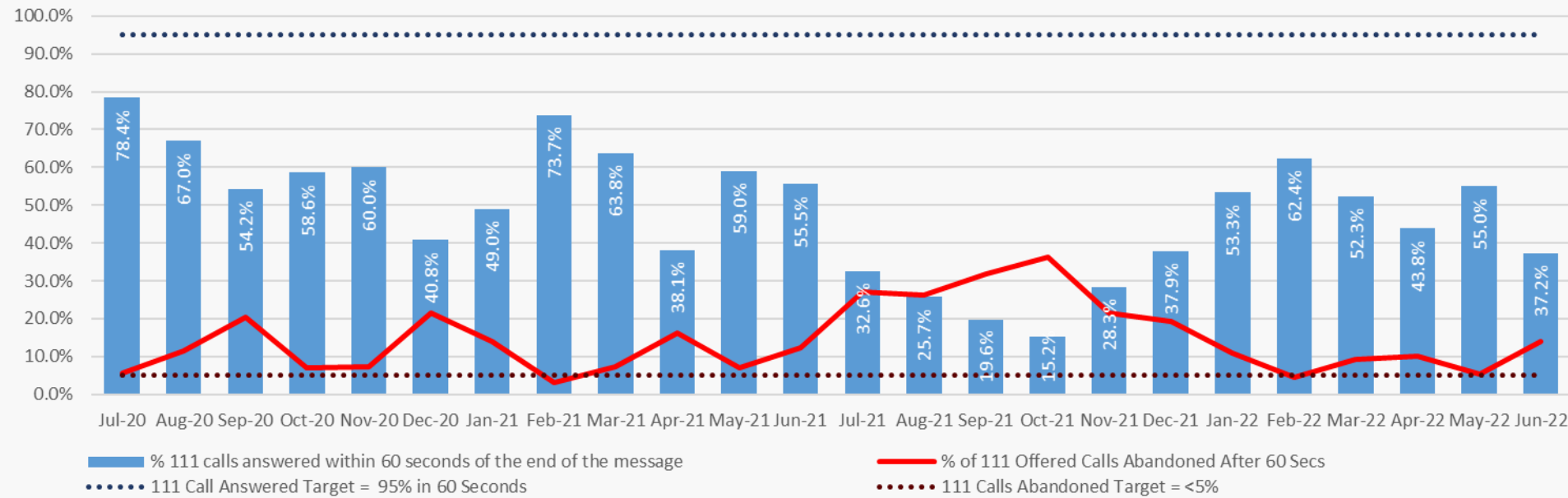
111 Call Answering/Abandoned Performance Indicators



Influencing Factors – Demand and Call Handling Hours Produced

**NB: June 2022 111 Shift fill data unavailable

111 Calls Answered vs Calls Abandoned within 60 Seconds



Analysis

111 call abandonment is a key patient safety indicator for the service. June 2022 saw a decline (worsening) in abandonment rates to 14%, therefore failing to meet the 5% target.

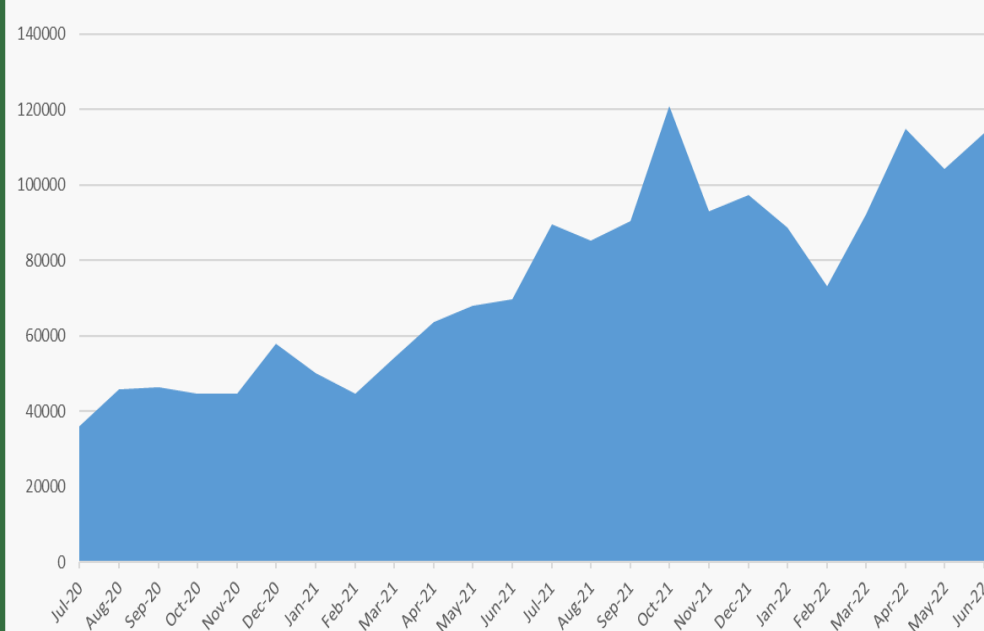
The percentage of 111 calls answered within 60 seconds of the end of the message also declined in June 2022 to 37.2%. Given the continued high volumes of calls per month, this still represents a significant number of people who receive a patient experience which didn't meet the levels achieved in February 2022 (62.4%).

111 call demand increased in June 2022 compared to the previous month, as seen in the graph.

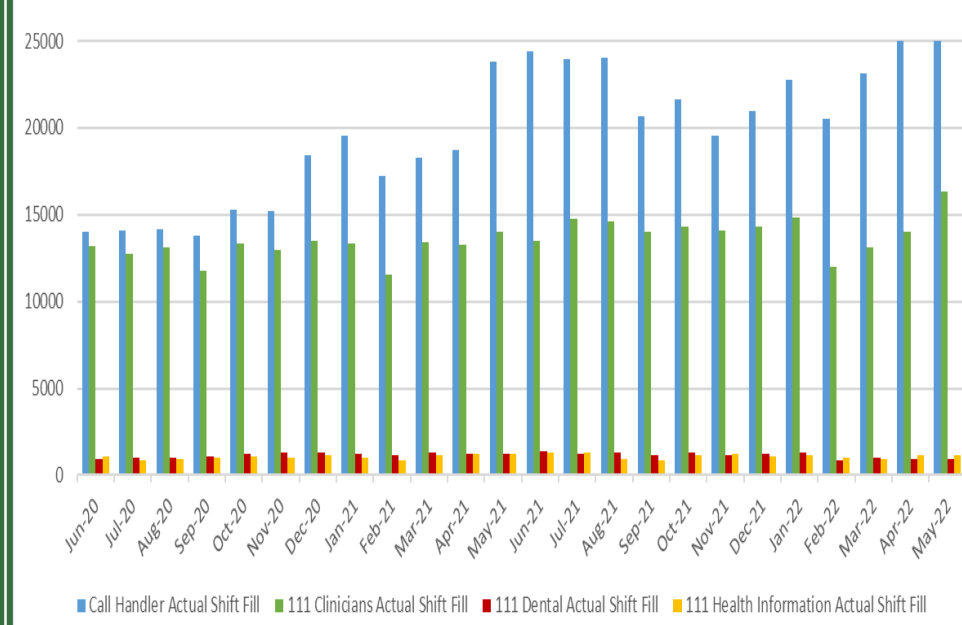
The graph alongside also shows that capacity (staff hours) has been increasing in line with the roll-outs and as planned; however, despite recruiting significant numbers of additional staff as agreed with commissioners, although sickness absences (which includes COVID-19 Sickness) reduced they remain high at 12.93% for NHS111 in May 2022. This means that demand is higher than forecast, capacity is lower than planned leading to the longer average call answer times as seen.

Communication regarding the use of 111 is regularly circulated to the public, which includes utilising online 111 Wales; in June 2022 there were 335,889 visits to the website. In June 2022 the top viewed pages were COVID which accounted for 19,454 followed by leg pain symptom checker which accounted for 16,090 hits and dental searches which recorded 11,700 hits.

Total 111 Calls Offered



NHS111 Shift Fill - Total Actual Hours



Remedial Plans and Actions

- The key to improving call answering times is having the right number of call handlers, rostered at the right time to meet demand, and to maximise efficiency. Discussions are ongoing with commissioners to confirm the commissioned WTE for call handlers, which we think will be around 178 WTE. We are currently broadly at that number with no vacancies.
- Work continues on sickness absence in line with the Trust's managing absence work programme
- Work is underway to look at the rosters and ensure that capacity is aligned to demand, and to try and even out performance through the week
- Work also continues in reviewing the use of the Clinical Advice Line which is available to call handlers who want some clinical advice whilst on call with the patient. The call handler has to wait for a clinician to answer the call and therefore the time spent is related to clinician availability. At present there are high levels of vacancies

Expected Performance Trajectory

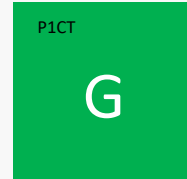
With call handler numbers broadly at commissioned levels, call answering times will only be improved through improved efficiency gains (reducing sickness absence, re-rostering, reducing time for CAL line)





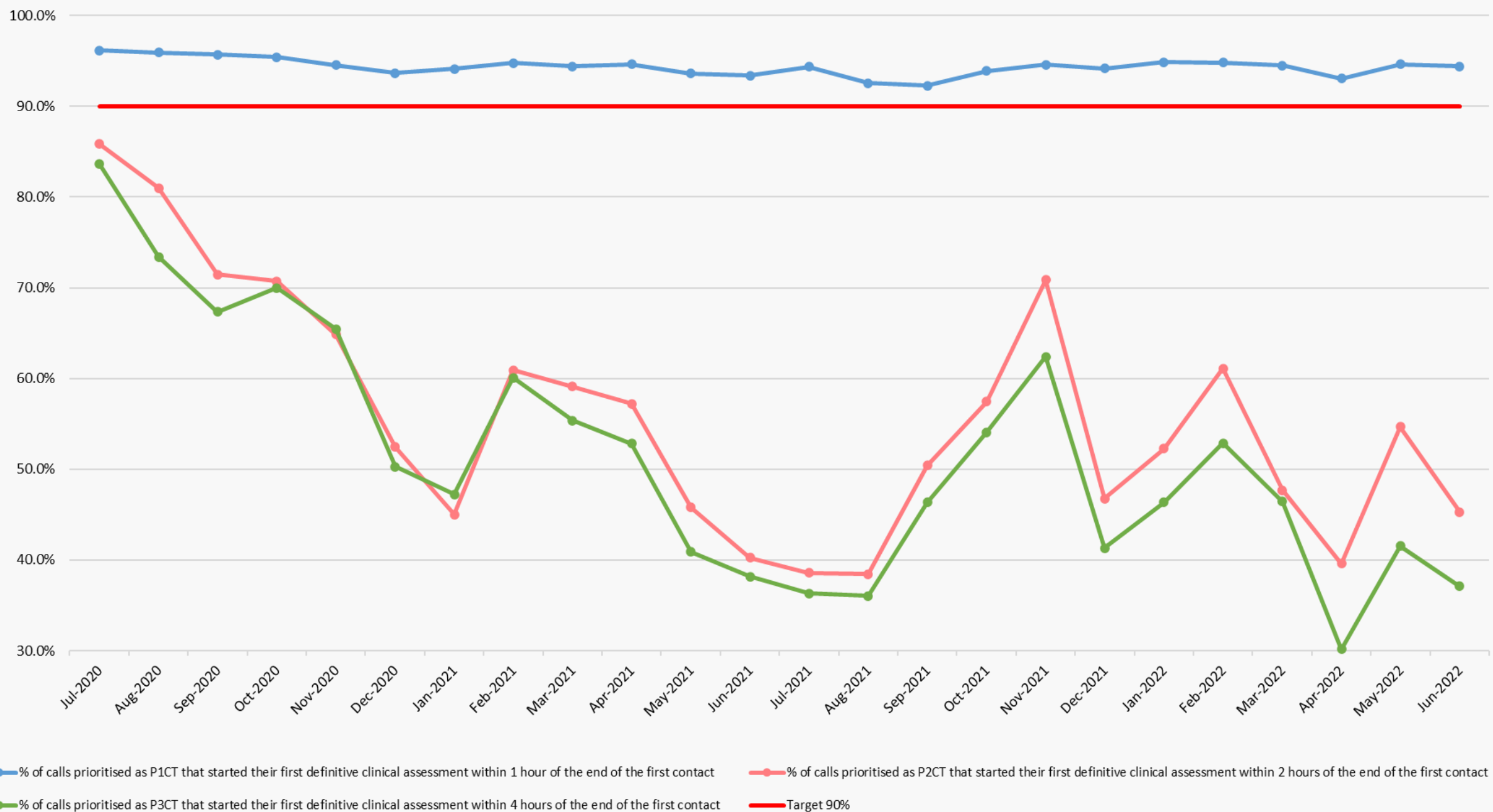
Our Patients: Quality, Safety & Patient Experience

111 Clinical Assessment Start Time Performance Indicators



Influencing Factors – Demand and Clinical Hours Produced

111 Timely Clinical Triage of Patients



Analysis

The performance of 111 calls receiving a timely response to start their definitive clinical assessment remains a challenge, with the continuing exception of the highest priority calls.

The highest priority calls, P1CT, continue to receive a timely response which has continuously achieved the 90% target over the last 2 years.

For lower category calls the Trust is still not meeting the 90% target, and, in June 2022 a decline was seen in all categories.

Demand for the service continues to grow (see previous slide) which will affect performance, but in addition, recruitment and retention of clinical staff also remains problematic.

Remedial Plans and Actions

The main driver of improved performance will be the correct number of clinicians in post to manage current and expected demand. At present there are significant numbers of clinical vacancies. Urgent consideration is being given to an updated action plan which may include:

- Utilisation of other clinicians to fill vacancies
- Maximising opportunities through agile working
- Review of existing staff bases
- Review of service model
- Targeted recruitment drive

Expected Performance Trajectory

Risks have been highlighted in previous reports about the ability to recruit sufficient clinicians and this is now being seen. Urgent work is now underway to agree a series of actions that might help to increase recruitment, reduce turnover and reduce demand on clinicians, but performance is likely to be poorer than the Trust would want for some time to come.



(Responsible Officer: Lee Brooks)

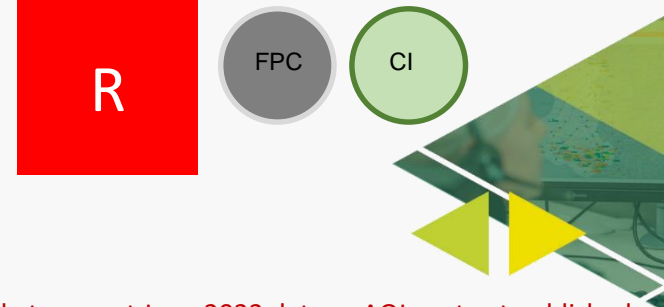
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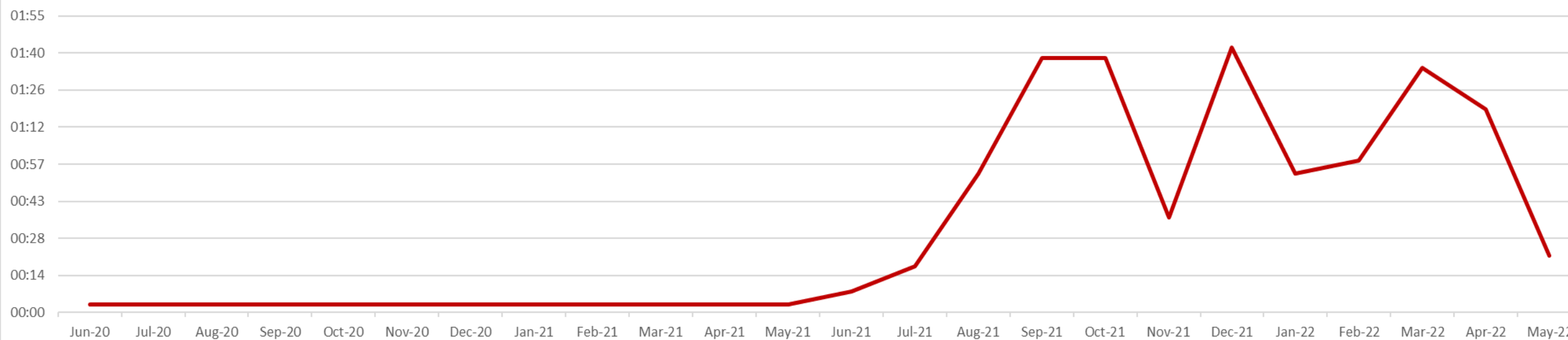
999 Call Performance Indicators

Influencing Factors – Demand and Clinical Hours Produced



**NB: Unable to report June 2022 data as AQIs not yet published

95th Percentile 999 Call answer times



Analysis

The 95th percentile 999 call answering performance saw a significant improvement in May 2022 to 22 seconds, compared to 1 minute 19 seconds in April 2022. Although this is an improvement it still failed to meet the 6 second answer target for the tenth consecutive month largely as a result of increased call demand, particularly at weekends. Increasing call answering times are a significant concern in relation to patient safety.

The median call answer times for 999 services remains consistently at 2 seconds. In May 2022 65th percentile continued to average at 3 seconds.

The Trust received 45,671 emergency 999 calls in May 2022, a decrease compared to April 2022, higher than May 2020 but lower than May 2021. The continued high call volumes are likely to be a result of public activity returning to normal levels, along with the impact of the continuing pandemic. Although not shown here, May 2022 saw a reduced level of staff abstraction due to sickness and COVID (12.93%), however this continues to reduce capacity within the call centres.

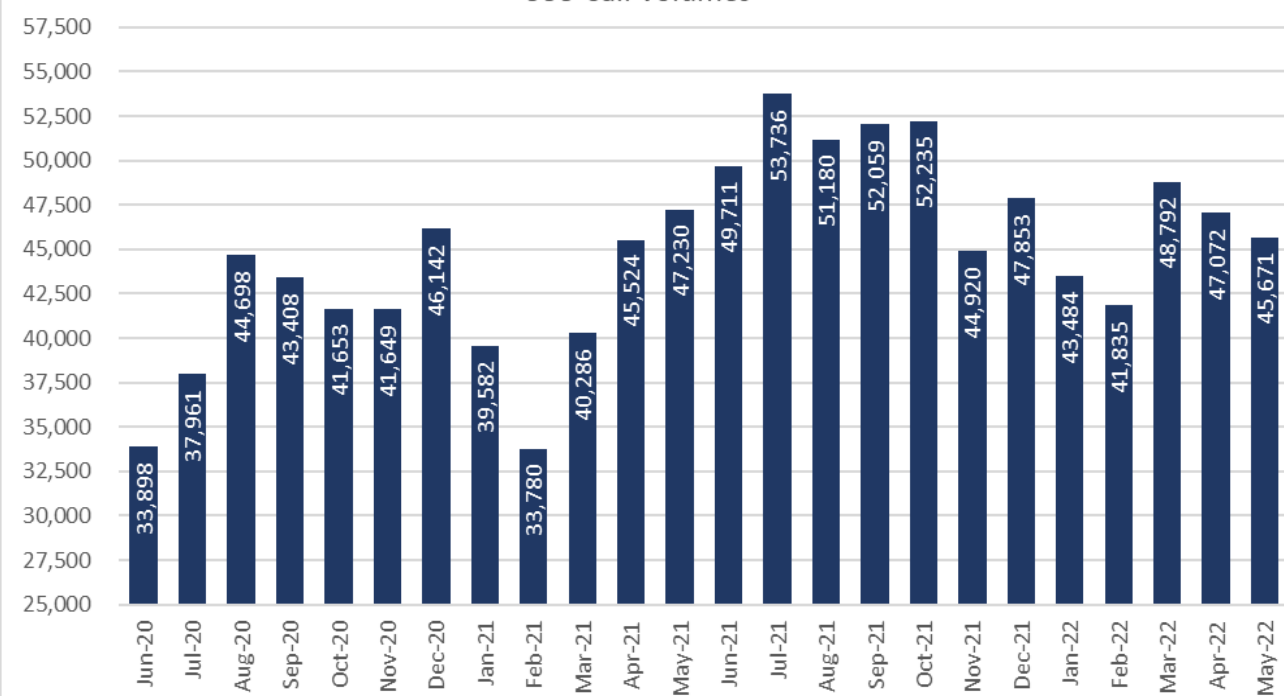
Remedial Plans and Actions

- EMS Co-ordination meet twice weekly to review demand profiles and align staffing levels appropriately. Resources teams are focussing on balancing capacity across the 7 day period, targeting overtime to weekends and Mondays where patterns of demand and reduced UHP are identified.
- Additional funding original approved has been withdrawn this fiscal year and as such EMD establishment will remain at baseline demand levels within the financial envelope for EMS Coordination.
- Improvements in sickness absence are being sought through the actions of the managing attendance programme.

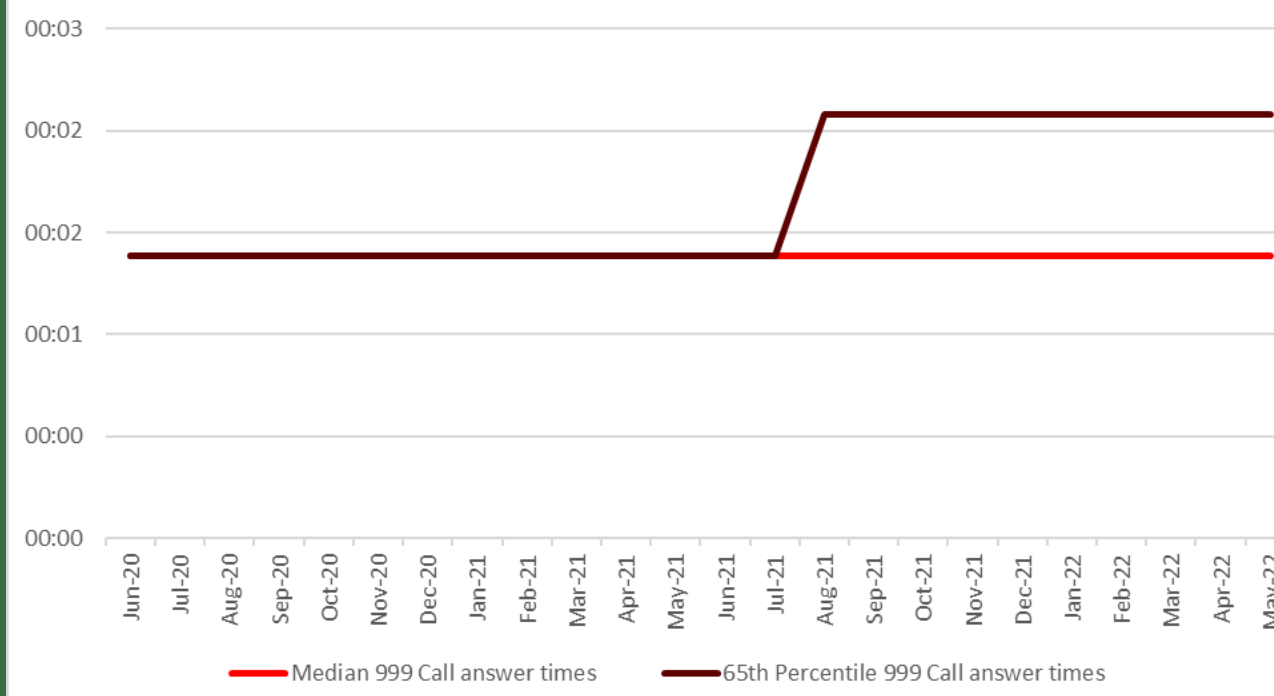
Expected Performance Trajectory

Performance is expected to continue to be difficult with demand forecasted to increase throughout the fiscal year. EMS Coordination continue to focus on proactive recruitment to mitigate the impact of current attrition rates

999 Call Volumes



Median & 65th Percentile 999 Call Answer Times



(Responsible Officer: Lee Brooks)

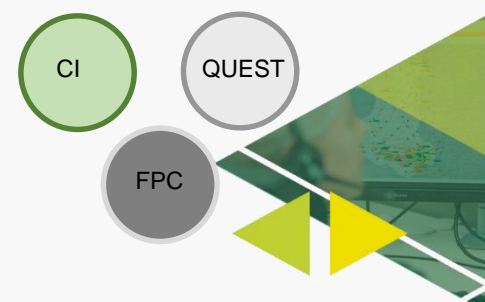
Welsh Ambulance Services NHS Trust



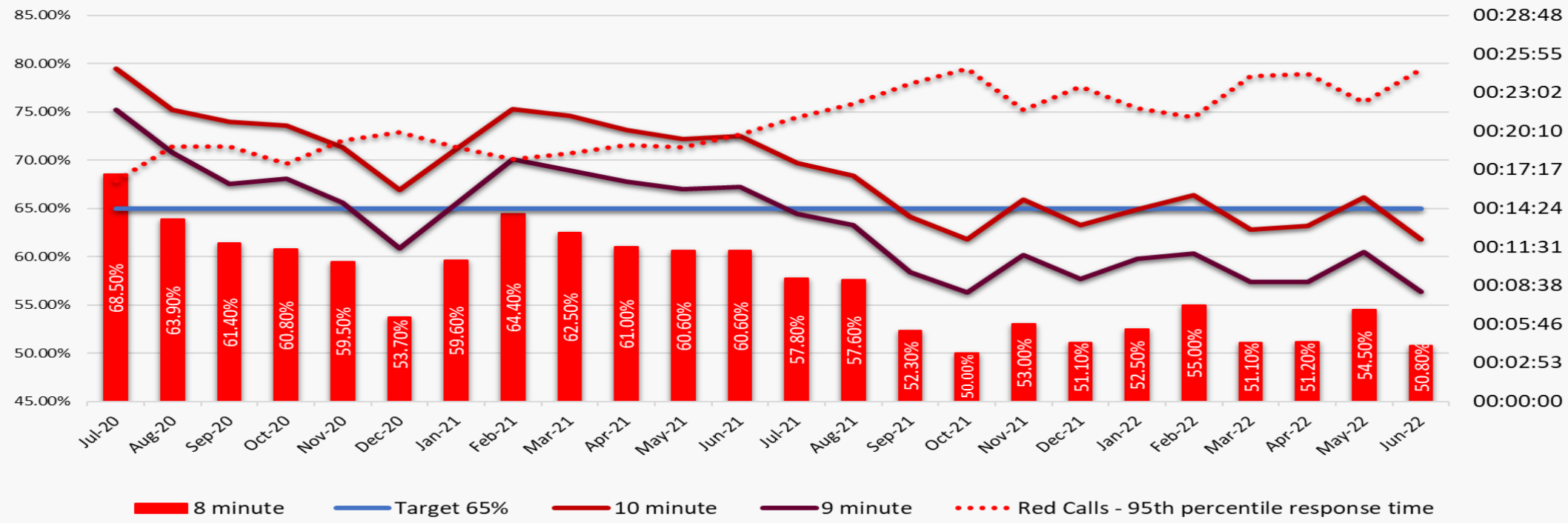
Our Patients: Quality, Safety & Patient Experience

Red Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



% Of Emergency Responses to Red Calls Arriving Within (up to and including) 8, 9 & 10 Minutes Against Red Calls 95th Percentile



00:28:48
00:25:55
00:23:02
00:20:10
00:17:17
00:14:24
00:11:31
00:08:38
00:05:46
00:02:53
00:00:00

Analysis

Red performance declined in June 2022 and did not achieve the 65% target; the target has not been achieved since July 2020. There was also significant health board level variation with none of the seven health board areas achieving the 65% target. A continuing level of poor performance was forecast in the spring plan based on predictions of demand, lost hours and hours produced. Red 10 minute performance was 61.8% in June 2022.

Three of the main determinants of Red performance are Red demand, unit hours produced, and handover lost hours.

Red demand in the last 2 years has seen a particular increase, outside of normal expected variation which is impacting on response times. Demand is not expected to decrease and the current levels have been built into forecasting and modelling work.

The lower centre graph demonstrates the correlation of performance with hospital handover lost hours, with extreme levels of losses continuing to be seen with 23,387 hours lost in June

The number of EA and RRV actual hours produced decreased slightly in June 2022 compared to May and were lower than planned, with continuing high (though reduced) levels of abstraction due to sickness absence (c10%)

There are many other factors which affect red, including additional time taken to don level 3 PPE to Red calls relating to some respiratory disease/issues (this requirement remains in place)

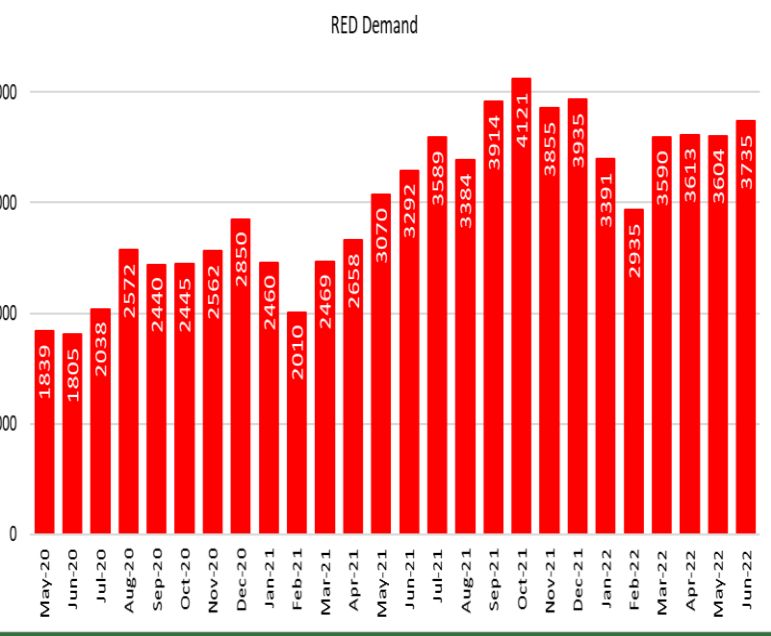
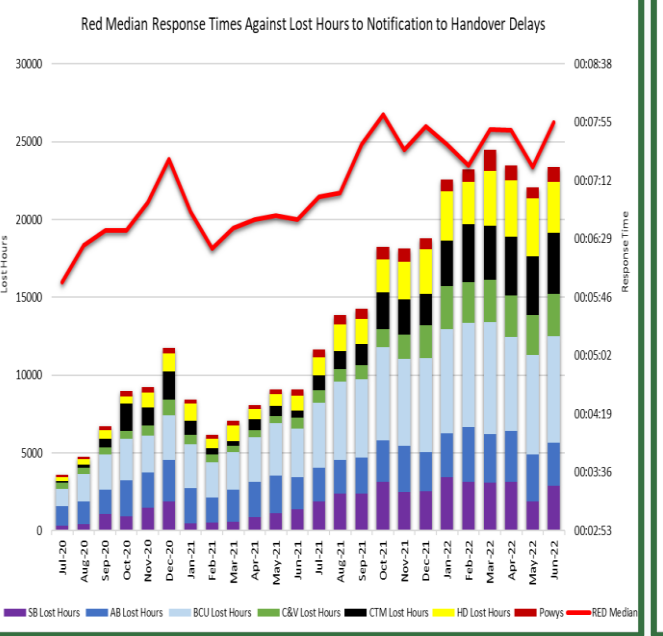
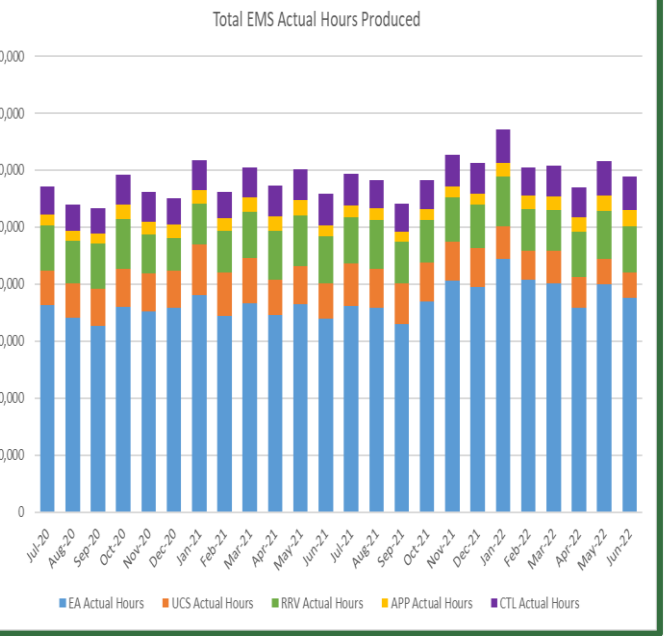
Remedial Plans and Actions

The main improvement actions are:

- Increase capacity where funded - recruitment of 100 FTEs, EMTs and ACA2s during 2022/23.
- Reduce hours lost through sickness absence through managing attendance programme – trajectory for improvement in place as part of IMTP.
- Increasing capacity through modernisation of practices and supporting staff well-being. This is under discussion with TU partners currently.
- Working with partners to reduce hours lost at hospital. Handover reduction plans and trajectories are currently being developed by health boards facilitated by the NCCU. Agreement on immediate release and fit to sit, together with commitment to no >4 hour waits and a reduction in 25% overall.
- Improving efficiency – new rosters to be implemented September – November. Equivalent of 72 WTE additional staff
- Implementation of CHARU service as part of new rosters will positively impact on red performance in particular. It is only partially funded however. .

Expected Performance Trajectory

Modelling through the summer forecasts continued poor red response times, if no reduction in hospital handover delays are seen in particular.



(Responsible Officer: Lee Brooks)

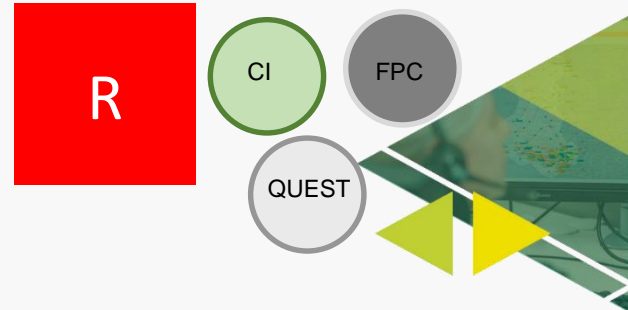
Welsh Ambulance Services NHS Trust



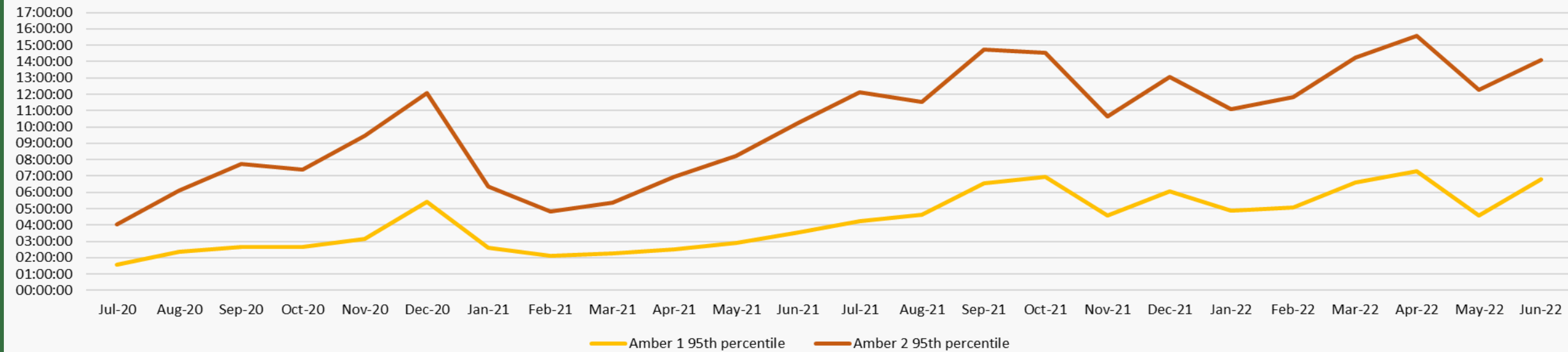
Our Patients: Quality, Safety & Patient Experience

Amber Performance Indicators

Influencing Factors – Demand, Hours Produced and Hours Lost



Amber 1 & 2 - 95th Percentile



Analysis

Amber performance declined across the percentiles in June 2022. In addition, there were still some very long patient waits. The ideal Amber 1 median response time is 18 minutes.

In June 2022, 744 patients (all categories, not just Amber) waited over 12 hours, an increase when compared to May 2022, continuing to represent a very poor quality and experience of service. 611 of these patients were in the Amber category.

Amber demand increased in June 2022 and activity remains at a high level, additionally continuing high handover continue to affect performance.

There is strong correlation between Amber performance and lost hours due to notification to handover delays, as demonstrated in the graph on the bottom left of this page. The number of hours lost to notification to handover delays in June 2022 increased to 23,387, remaining higher than the worst recorded in December 2019 (13,820).

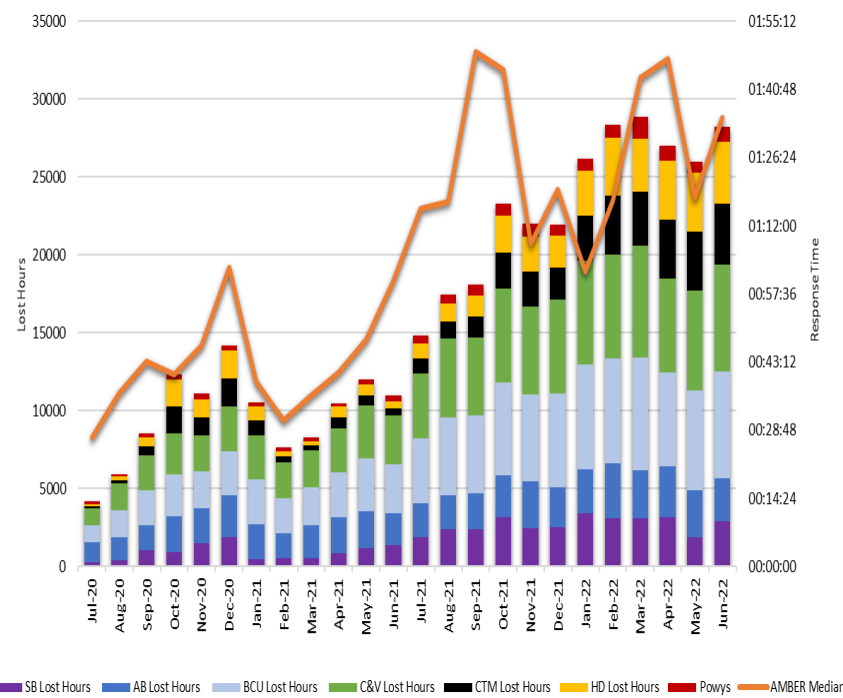
Remedial Plans and Actions

The Trust carefully monitors long response times and their impact on patient safety and outcomes. The Trust supplies regular information to the CASC and EASC; and from November 2020 the Trust began producing monthly quality, safety & patient experience (QSPE) reports for each health board. The actions being taken are largely the same as those related to Red performance on the previous slide.

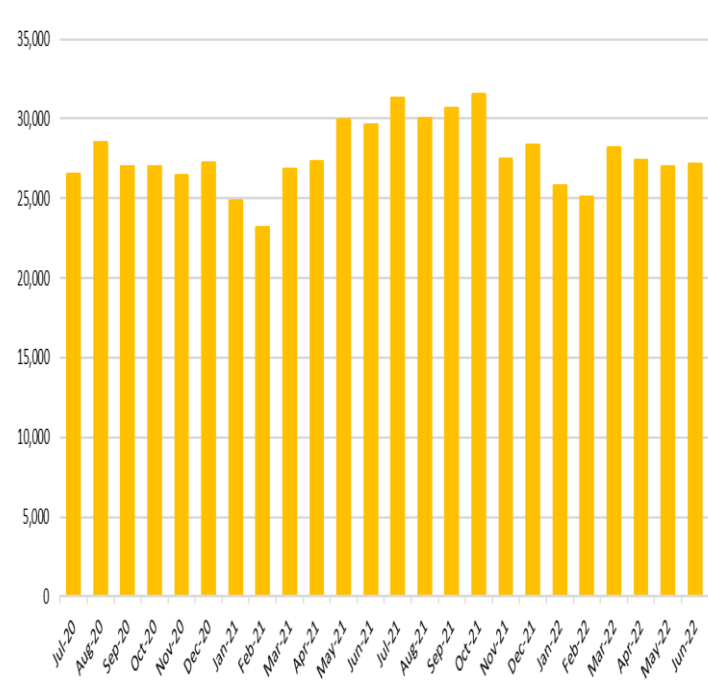
Expected Performance Trajectory

The EMS Operational Transformation Programme is the Trust's key strategic response to Amber. As per the commentary on Red performance delivering these benchmarks is dependent on a range of investments, efficiencies and system efficiencies, not all of which are within the Trust's control, and which are unlikely to show improvement in the coming months.

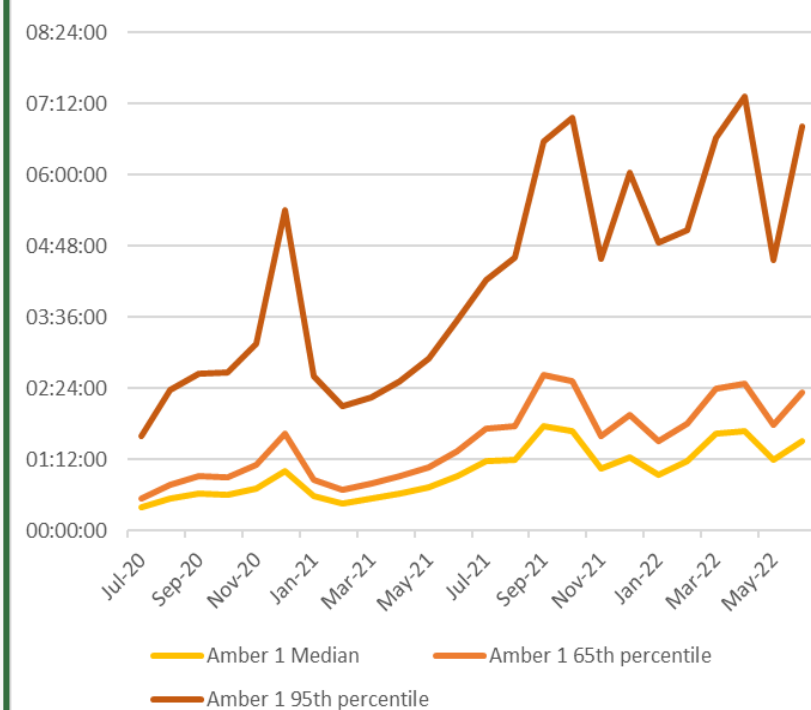
Amber Median Response Times against Lost Hours to Notification to Handover Delays



Total Verified AMBER Demand



Amber 1 Median, 65th and 95th Percentile



(Responsible Officer: Lee Brooks)

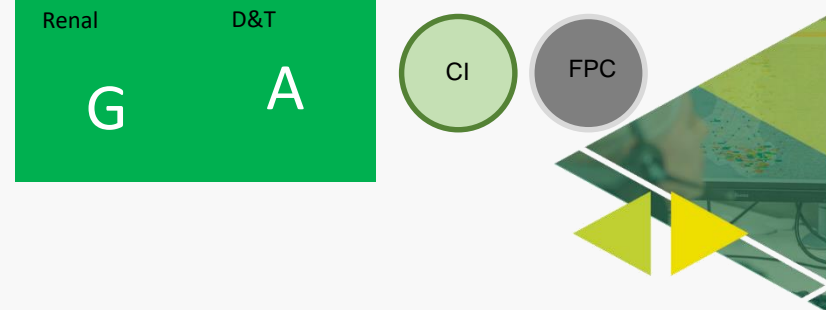
Welsh Ambulance Services NHS Trust



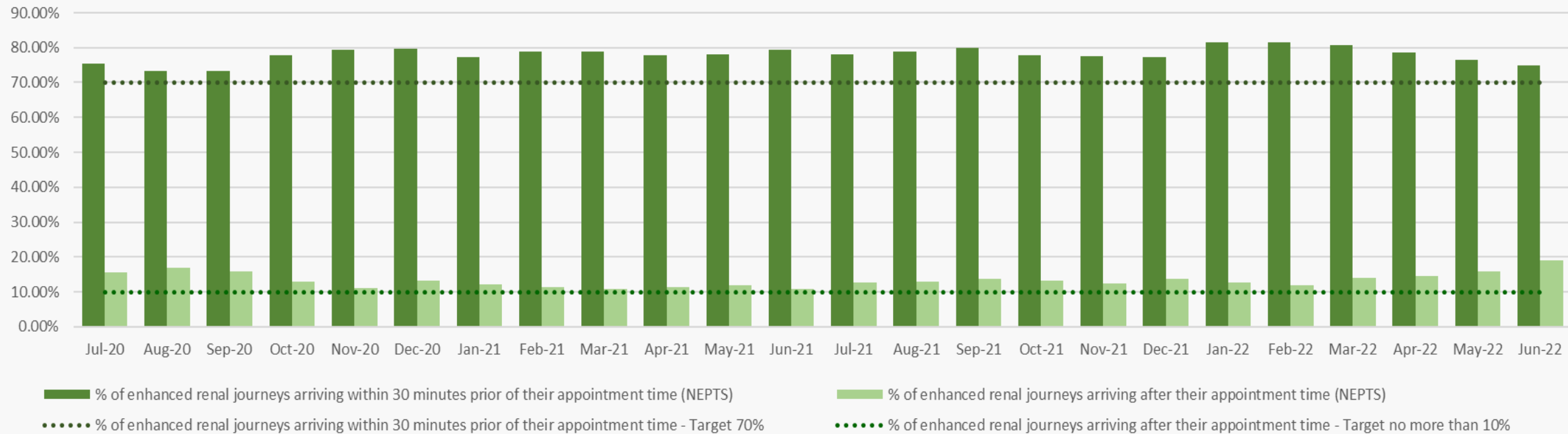
Our Patients: Quality, Safety & Patient Experience

Ambulance Care Indicators

Patient Experience



% Of Enhanced Renal Journeys - Arrival Times (NEPTS)



Analysis

Ambulance Care has seen a stabilisation of areas of service delivery affecting patient experience. In June 2022 87% of discharge & transfer journeys were collected within 60 minutes of their booked ready time, therefore not achieving the 90% target and a decline compared to May 2022 (90%). 74.9% of enhanced renal journeys arrived within 30 minutes prior to their appointment time, achieving the 70% target and 19.1% arrived after their booked appointment time, falling outside of the 10% target.

Key factors affecting these indicators are demand and capacity:

- **Social distancing on transports:** this ended in June 2022 so there is no reduction in capacity because of this.
- **Capacity** continues to be adversely affected by other factors such as sickness absence levels, which were at 9.49% in May;
- Overall demand has been increasing since the initial reduction at the beginning of the pandemic, but overall it is still not quite at pre-pandemic levels.
- As the Trust emerges out of pandemic response and the health system is “re-set” it is anticipated that further demand increases could be experienced at which point capacity may be an issue. This has been modelled and mitigations put in place.

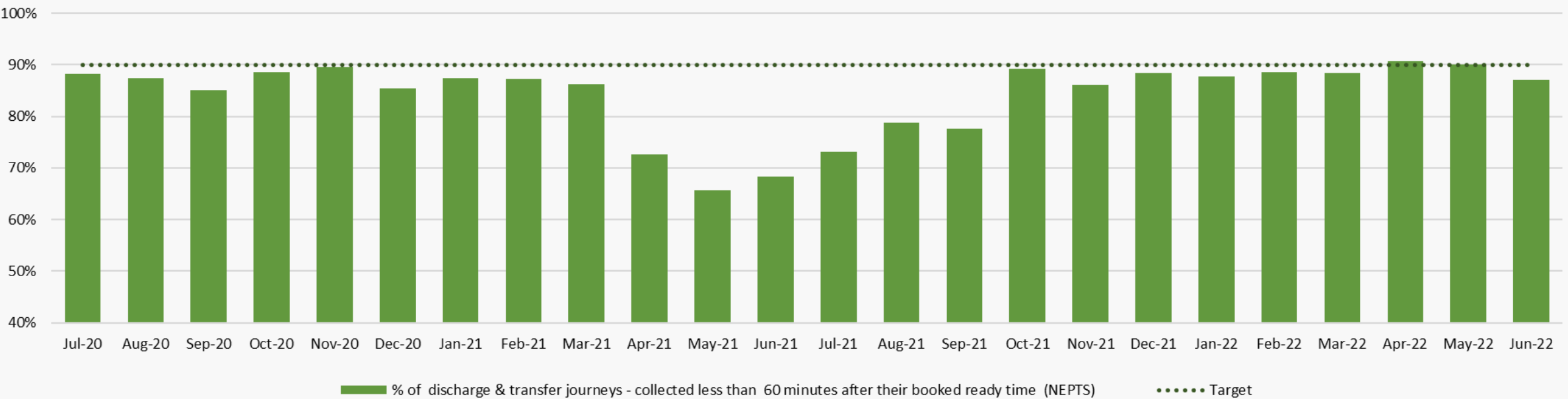
Remedial Plans and Actions

- **Demand:** Continue to work with health boards to understand and model the impact of their recovery plans;
- **Demand:** In the absence of additional funding, the service has implemented a capacity management plan to assist it in ensuring it remains within budget and prioritises resources for those most in need
- **Efficiencies:** Work is underway on actions to improve efficiency, including those actions identified through the D&C review, in particular, re-rostering.
- **Capacity:** discussions with EASC on options for balancing demand and capacity.

Expected Performance Trajectory

At present, the uncertainty around demand and future impacts of the pandemic and system recovery means that it is difficult to forecast performance; however, it is likely that the service will experience both positive and negative fluctuations of performance until activity normalises across the system.

% of discharge & transfer journeys - collected less than 60 minutes after their booked ready time (NEPTS)



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Patient National Reportable Incidents & Patient Concerns Responses Indicators

SCIF. **A**

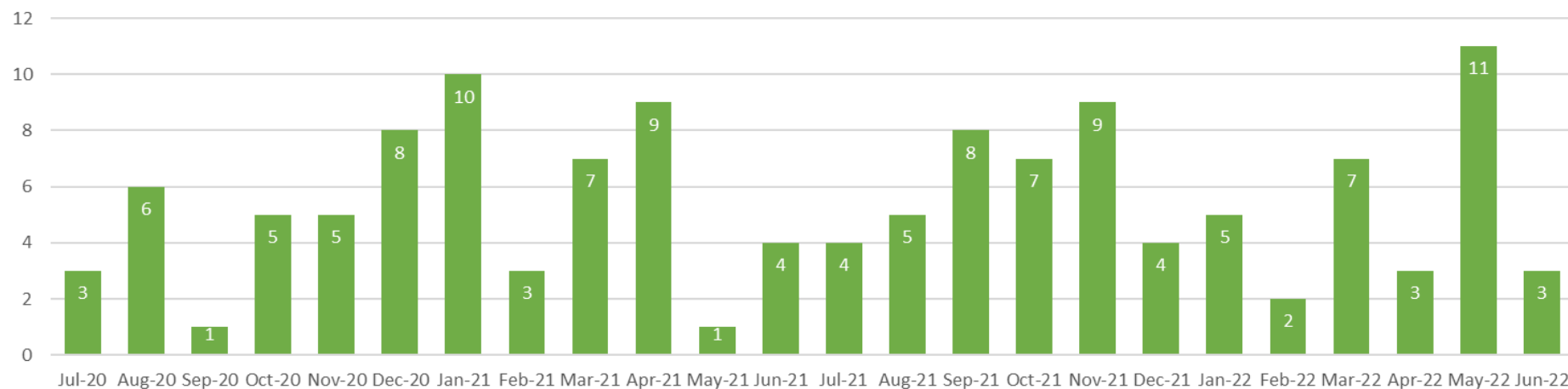
Self Assessment:
Strength of Internal
Control: Moderate

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Timely Care

****NB: Unable to report June 2022 Concerns data**

Number of SCIF cases reported as National Reportable Incidents (NRI) By Date Reported to the Delivery Unit by WAST



Analysis

The **percentage of responses to concerns declined again in May 2022 to 41%**, compared to 53% in April 2022, therefore not achieving the 75% target. Several factors continue to affect the Trust's ability to respond to concerns, including, overall increased demand, a rise in the number of inquests, continuing volumes of NRI's and the availability of other departments to provide a timely response to requests for information. The number of total concerns decreased in May 2022 (75) when compared to April 2022 (90).

There were 8 SCIF forums held in June 2022, during which 47 cases were discussed, 3 of these cases were reported to the Delivery Unit and 24 were passed to Health Boards as National Reportable Incident Framework 'Appendix B' incident referrals.

Year on year the overall volumes of NRIs is on an increasing trend. The sharp increase seen in September – November 2021 and again in March and May 2022 is concerning and has been linked to the significant delays across the system along with the continued levels of NRIs. In May 2022 there were 0 NRIs relating to Red calls, 6 relating to Amber calls and 0 relate to Green calls. There were 5 NRIs as a result of calls prioritised Amber which should have been Red.

At present it is not possible to report on the number of cases within the Complex Case Panel and Redress due to the implementation of the new Once for Wales Datix RL system.

As reported earlier, in June 2022 744 patients waited over 12 hours, an increase month on month, and when compared to 330 in June 2021 and 5 in June 2020.

37 Compliments were received from patients and/or their families in June 2022, a slight decrease compared to the previous month (38).

Remedial Plans and Actions

A range of actions are in place:-

- The general theme in relation to the Trust's concerns portfolio is timeliness to respond.
- There is continued engagement with Health Boards in relation to Joint investigations where the primary causal factor is in relation to delayed handover.
- Concerns have been highlighted following a Delivery Unit report into the Health Boards handling of Appendix B cases, some of which should potentially have been reported as Nationally Reportable Incidents (NRI's) by the HBs.
- Health Board specific QSPE reports are being shared with each respective HB Directors of Nursing.
- The key strategic action is the EMS Operational Transformation Programme.

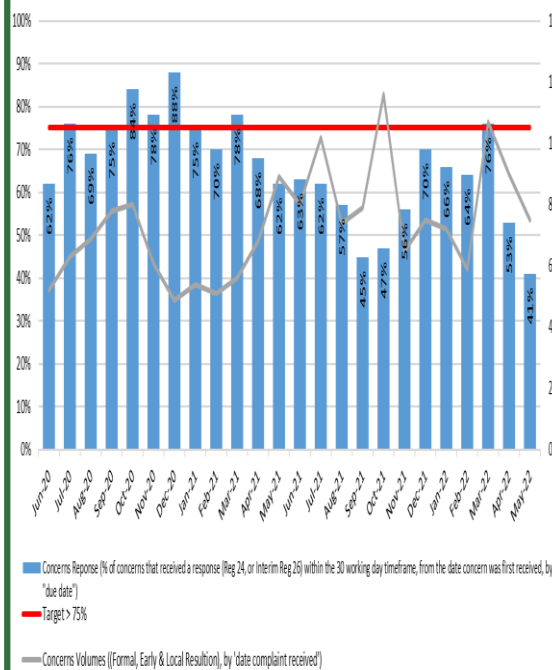
Expected Performance Trajectory

Following the end to Military assistance on 31 March 2022, the Trust is expecting continuing challenges with performance especially as hospital delays remain a significant challenge for the Trust.

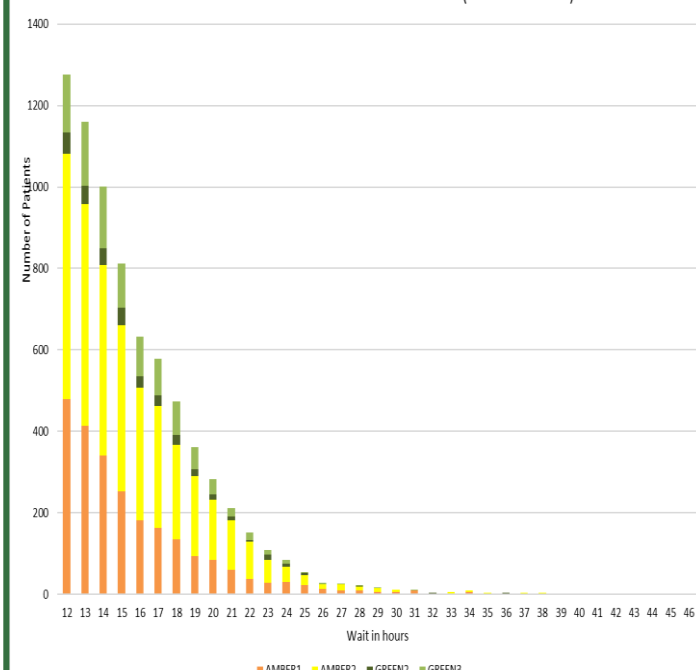
****NB: June 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change. At present reporting accurate data is not possible due to implementation of the Once For Wales Datix RL system.**

****NB: Complex Cases will always report one month in arrears**

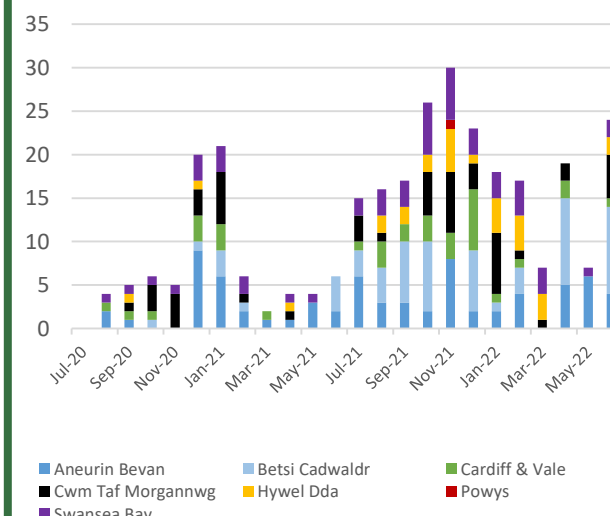
% of concerns with a response within 30 working days against concerns volumes



Number of Patient Waits over 12 hours by Priority Type Cumulative Position over last 12 months (Jul-21 to Jun-22)



Number of National Reportable Incident cases agreed to refer to Health Board reported as Serious Incident Framework 'Appendix B' HB referrals



NRI & Concerns Data source: Datix / Longest Waits Data Source: Report Manager



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Patient Safety Indicators

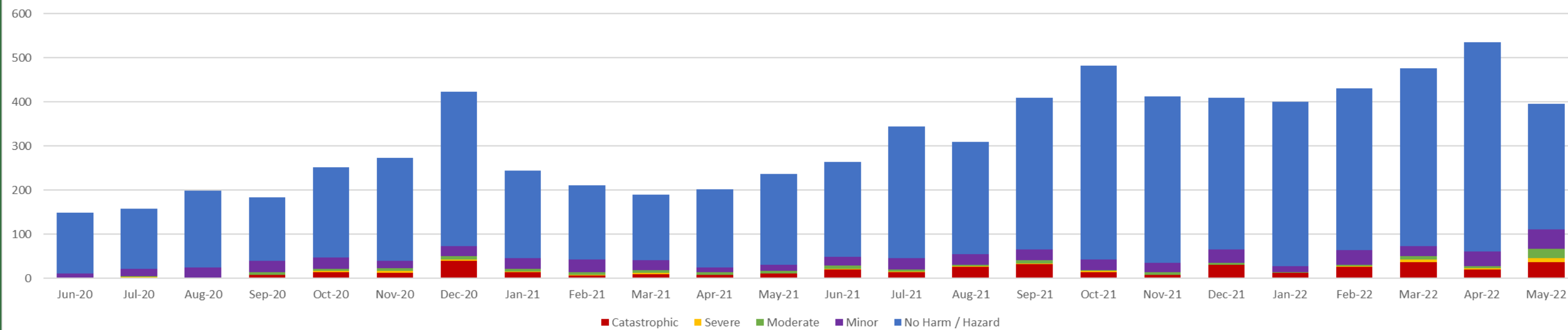
Self Assessment:
Strength of Internal
Control: Moderate

QUEST

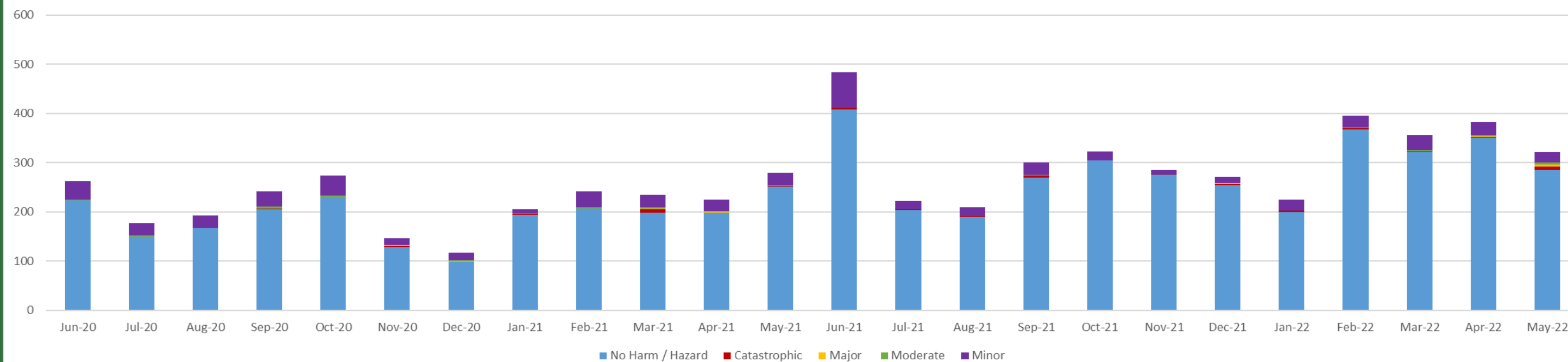
Health & Care
Standard
Health – Safe Care

****NB: June 2022 data not yet available for reporting**

Number of Incidents closed on Datix system within the reporting month, by harm grading (Volumes Received)



Number of Incidents closed on Datix system within the reporting month, by harm grading at point of closure (Volumes Closed)



Analysis

Patient Safety: The number of patient safety adverse incidents submitted within May 2022 increased to 396; 285 of these were in relation to incidents where there was no harm or hazard, 44 were minor, 22 were moderate, 9 were severe and 36 incidents were catastrophic. 324 cases were closed in May 2022 in comparison to 389 in April 2022.

Remedial Plans and Actions

Patient Safety: Capacity issues have impacted the ability of some teams in their ability to support investigations due to ongoing operational pressures related to the continued pandemic.

Expected Performance Trajectory

The Trust will continue to ensure lessons are learnt from every case reviewed and best practice will be implemented to continue to ensure care is of the highest quality.

****NB: May 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change.**
At present reporting accurate data is not possible due to implementation of the Once For Wales Datix RL system.

Data source: Datix



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

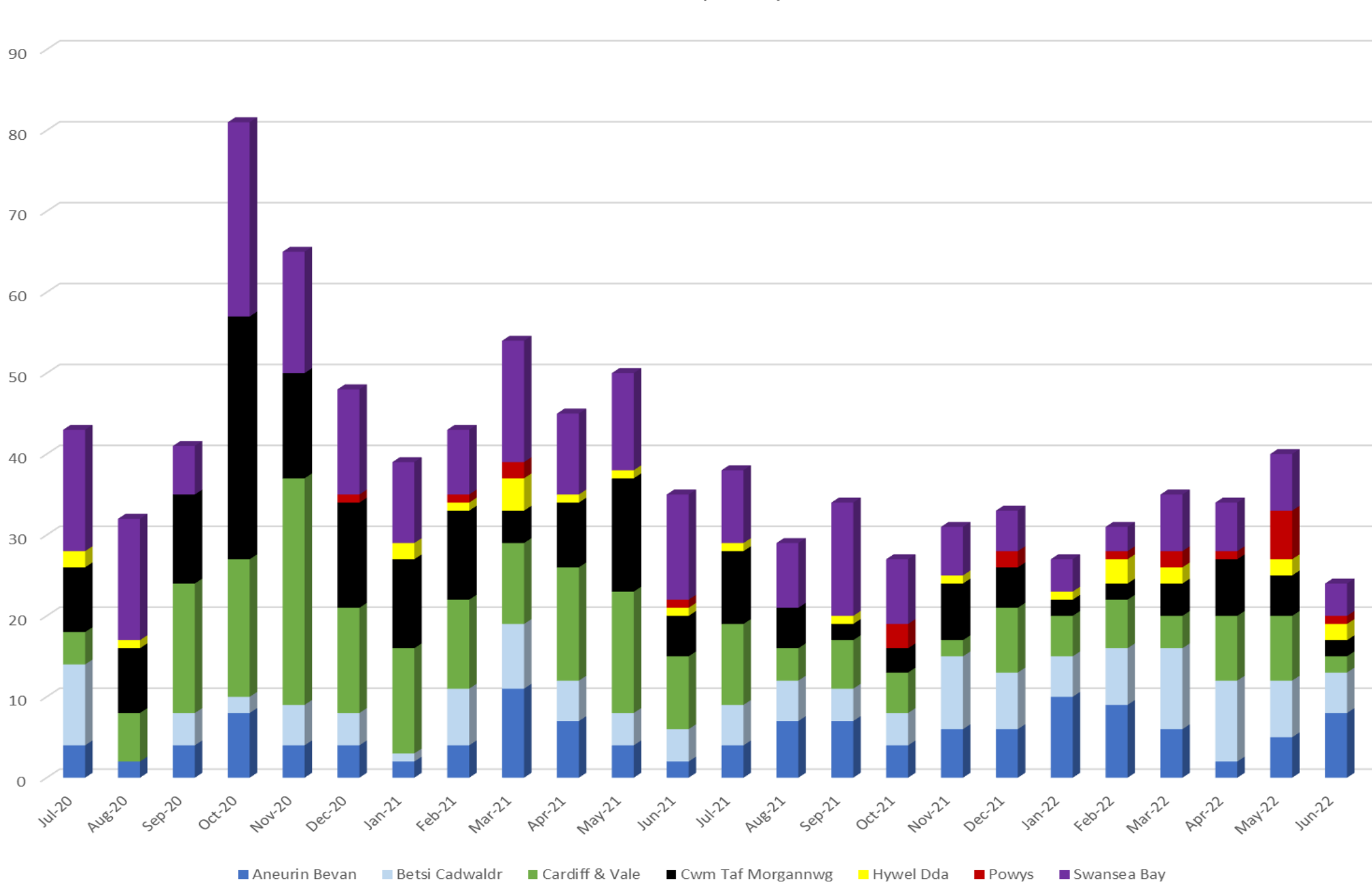
Coroners and Ombudsmen Indicators

Self Assessment:
Strength of Internal
Control: Strong

QUEST

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Number of Coroner Requests by Health Board



Analysis

Coroners: In June 2022, the number of in month requests remains at an increased level compared to pre-pandemic requests. The timeliness of our response and unexpected deaths continues to be the main themes. The Regulation 28 received relates to a delayed response and a patient being delayed at the hospital on arrival.

At the end of June 2022 there are 381 claims open; these relate to Personal Injury (70 Claims); Personal Injury - Road Traffic Accidents (43 Claims), Clinical negligence (105 claims); Road Traffic Accident (141 claims) and Damage to Property (22 claims).

Ombudsman: There are currently 18 open Ombudsman cases in May 2022. At present cases are not being investigated, which supports the Trusts actions.

Remedial Plans and Actions

Coroners: Cases continue to be registered and distributed in a timely manner. If there is likely to be a delay in responding the Trust ensures that the coroner is kept informed of the expected date of response. Inquests are being arranged for September - December at this time.

Ombudsmen: All cases are recorded and monitored on the Datix System..

Expected Performance Trajectory

Coroners: The Trust continues to focus on the learning from our investigations and report these via the Patient Safety Highlight report, which is presented to the Executive Management Team and Trust Board.

In addition to this, learning from our investigations continues to be presented to the Patient Safety, Learning and Monitoring Group and our Scrutiny Panels.

Individual learning it also a huge focus across the organisation with significant attention on both clinical and CCC areas of business.

We also continue to engage with our Health Board colleagues where we have utilised the Joint Investigation Framework and/or where there is a focus on joint investigations and learning.

Ombudsmen: The Trust will continue to ensure lessons are learnt from every case reviewed and best practice will be implemented to continue to ensure care is of the highest quality.

NB: June 2022 Ombudsmen data unavailable at time of reporting.

Data source: Datix



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Safeguarding, Data Governance & Public Engagement Indicators

Health & Care Standard
Health – Safe Care

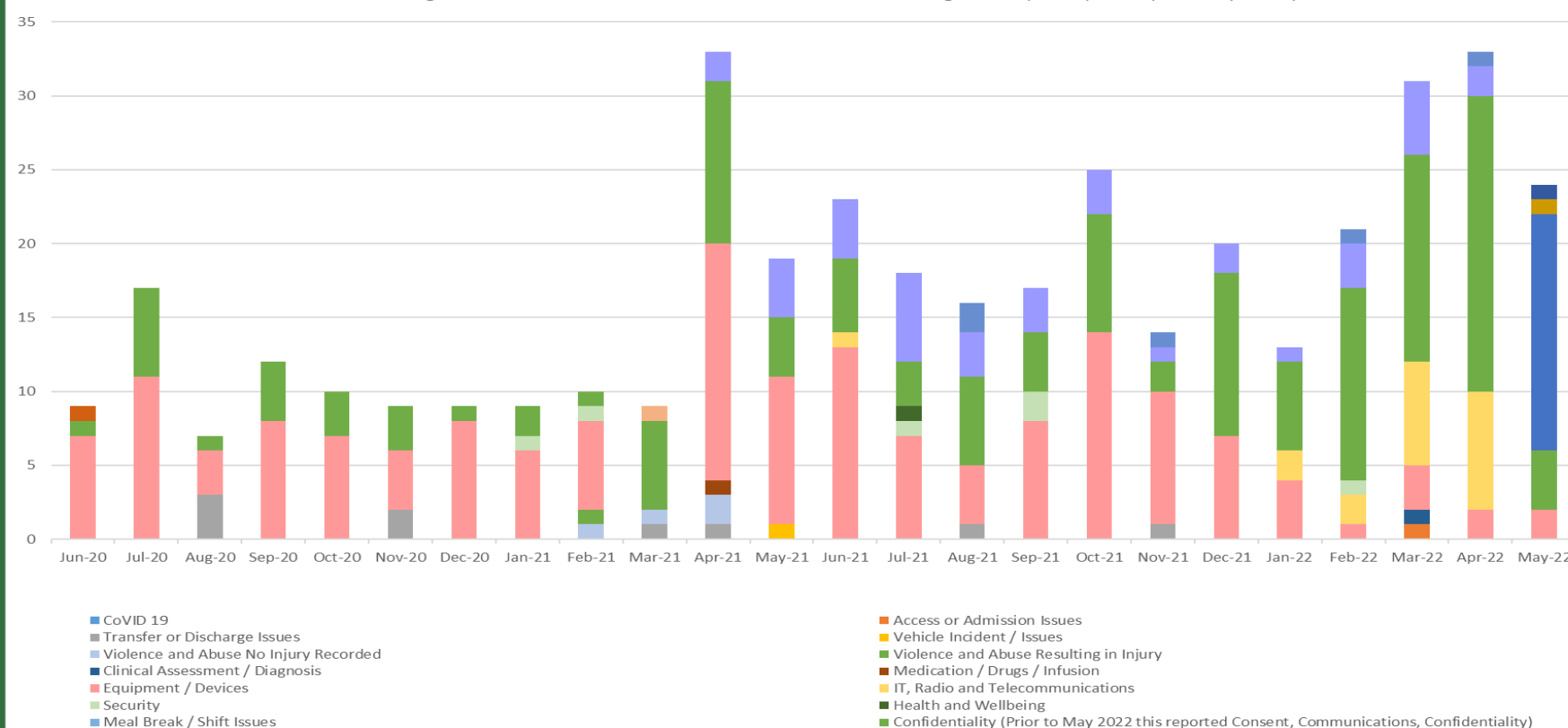
Self Assessment:
Strength of Internal Control: Strong

QUEST

NB: Public Engagement next update (Apr-Jun 22) due Jul-22

NB: June 2022 Safeguarding data unavailable at time of reporting.

Volume of High Level Breaches of the UK General Data Protection Regulation (GDPR) 2018 (Date Reported)



Analysis

Safeguarding: In May 2022 staff completed a total of 114 Adult at Risk Reports, a decrease compared to April 2022 when 97 were reported. 91% of these were processed within 24 hours.

There have been 187 Child Safeguarding Reports in May 2022, a decrease from April 2022 when 170 reports were made. In May 2022 95% were sent within 24 hours.

Data Governance: In May 2022 reporting for Data Governance transferred to the new Once For Wales Datix RL system; there were 24 information governance (IG) related incidents reported on Datix RL categorised as an Information Governance (IG) breaches, a decrease when compared to April 2022. 16 related to records/information, 4 were in relating to Confidentiality, 2 were related equipment / devices, 1 related to information technology and 1 related to communication. All have been investigated by the IG team and received feedback on the IG Policy and practice elements, and where appropriate learning has been put in place.

Public Engagement: There were 77 engagement events held in Quarter 4, allowing engagement with 1,450 people. Easing of COVID-19 restrictions has allowed the Trust to make a cautious return to face-to-face engagements within the community, along with a continuation of some online virtual engagement sessions. 68 NHS 111 Wales website surveys were returned, 28 people completed a new survey about their experience of calling NHS 111 Wales. The Trust continues working with NEPTS colleagues to promote patient experience surveys for users, surveys are sent direct via post, text and online. 280 NEPTS surveys were completed in this quarter. 131 compliments were also logged and processed and 104 people left comments, suggestions and messages through our 'Have Your Say' function on the Welsh Ambulance Service Website. Engaging with people and communities continues to be a priority for the PECEI Team, this engagement allows us to share important information about WAST services with communities and enables the collection of feedback and experiences which help us understand if services are meeting patient needs and expectations.

Remedial Plans and Actions

Safeguarding: The Trust primarily manages all safeguarding reports digitally via Docworks and regular monitoring of the system by the Safeguarding Team provides a means to identify any problems with delayed reports with appropriate action taken to support staff with the use of the Docworks Scribe App and liaise with local authorities when or where required. Numbers of paper safeguarding reports have significantly reduced with the embedding of Docworks; however, they are used as a back-up and are sent directly to the Safeguarding Team for further action. Continued monitoring supports practice in this area which is seeing a steady improvement.

Data Governance: During the reporting period, of the 24-information governance related incidents reported on Datix all incidents have been reviewed and investigated where necessary by the IG team and remedial actions taken where appropriate. 0 incidents were deemed to meet the risk threshold for reporting to the Information Commissioner's Office.

Public Engagement: Within this reporting period remaining COVID-19 restrictions ended, and the Trust made a cautious return to engaging with people and communities in person again. The PECEI Team are extremely happy to be engaging with people in person again and look forward to re-building relationships with groups and communities whom the Trust have not been able to meet due to the pandemic. To ensure the safety of our Team members and communities whilst we do this, the Trust have reviewed and updated our existing processes and risk assessments to incorporate some additional COVID-19 safety elements. Recognising that not all people feel ready to return to engaging with us in the way they would have before the pandemic, the Trust continues to offer opportunities to engage using online platforms that have become so familiar.

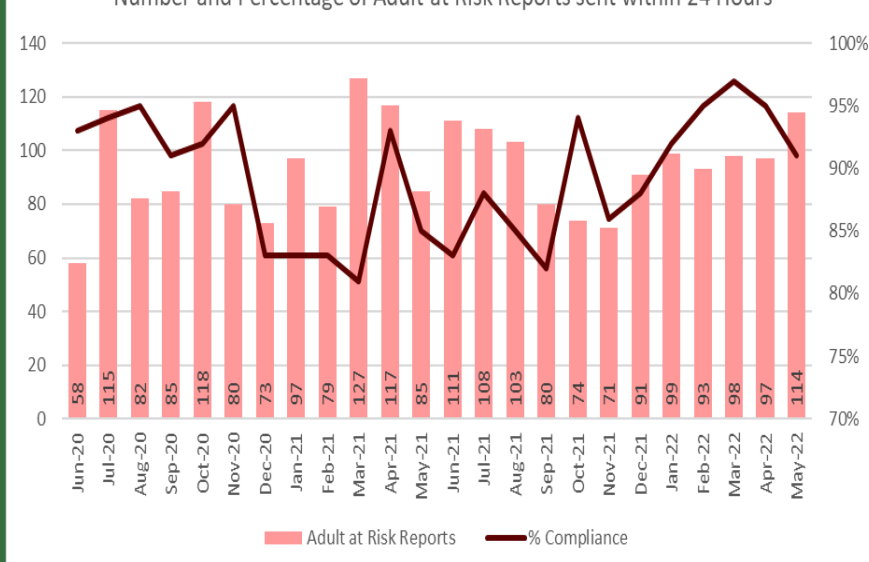
Expected Performance Trajectory

Safeguarding: The Trust continues to aim to achieve 100% of Adult and Children at risk referrals within 24 hours.

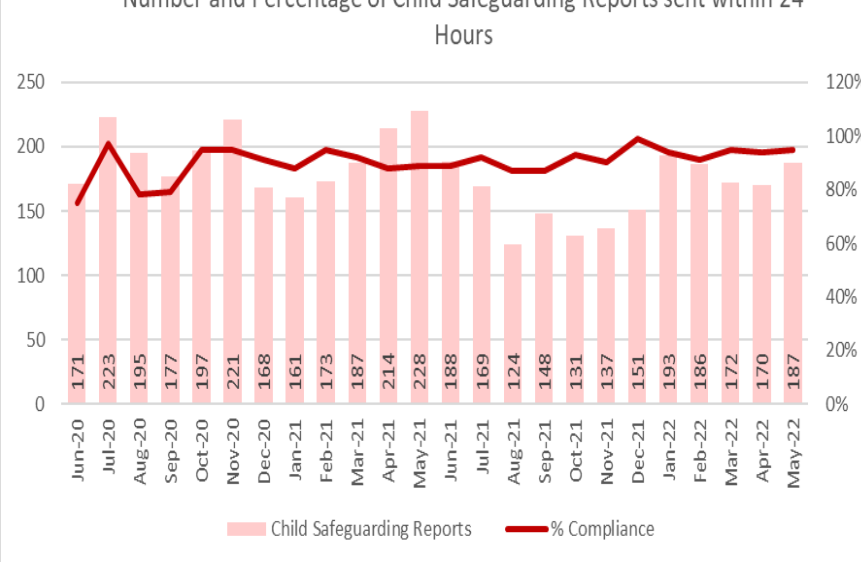
Data Governance: An annual assessment of compliance using the Welsh NHS IG Toolkit; an individual evidence-based assessment consisting of 255 items will continue to be utilised to measure the Trust against National Information Governance and Security Standards, and the Trust's FY21-22 IG Toolkit responses have now been submitted.

Public Engagement: The PECEI Team will continue to share good practice and learning from our engagement with partners, stakeholders and colleagues at Ambulance Services across the UK. The Trust will continue to proactively communicate with people and communities, sharing important information regarding Trust services, appropriate use of these during the current period of increased demand. With most coronavirus restrictions now lifted in Wales, the team are receiving invitations to engage with people and communities and are looking forward to attending these over the coming months.

Number and Percentage of Adult at Risk Reports sent within 24 Hours



Number and Percentage of Child Safeguarding Reports sent within 24 Hours



Safeguarding Data source: Doc Works



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Health & Safety (RIDDORS) Indicators

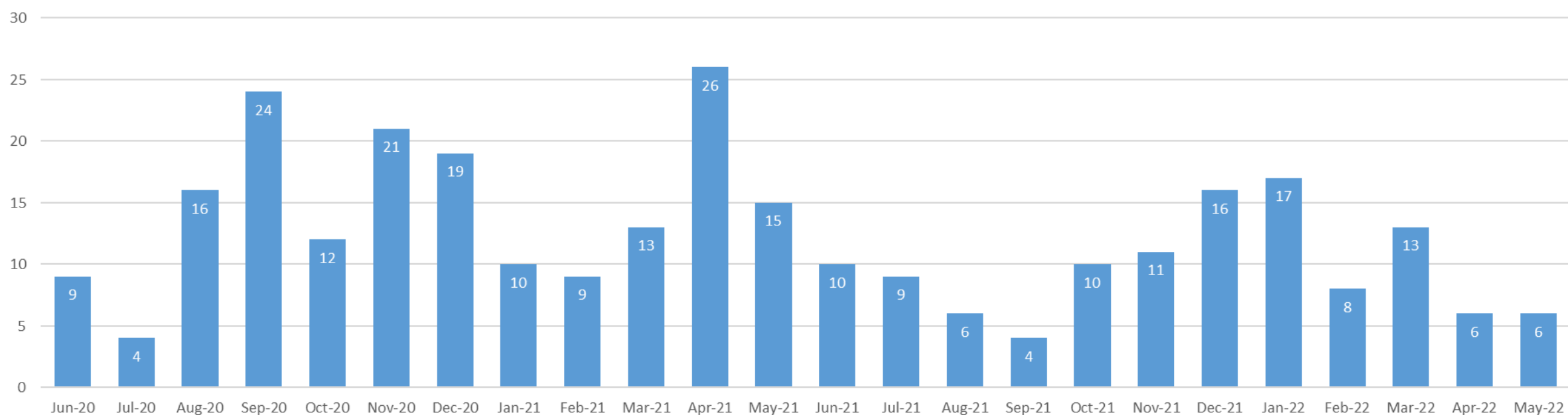
Self Assessment:
Strength of Internal
Control: Moderate

QUEST

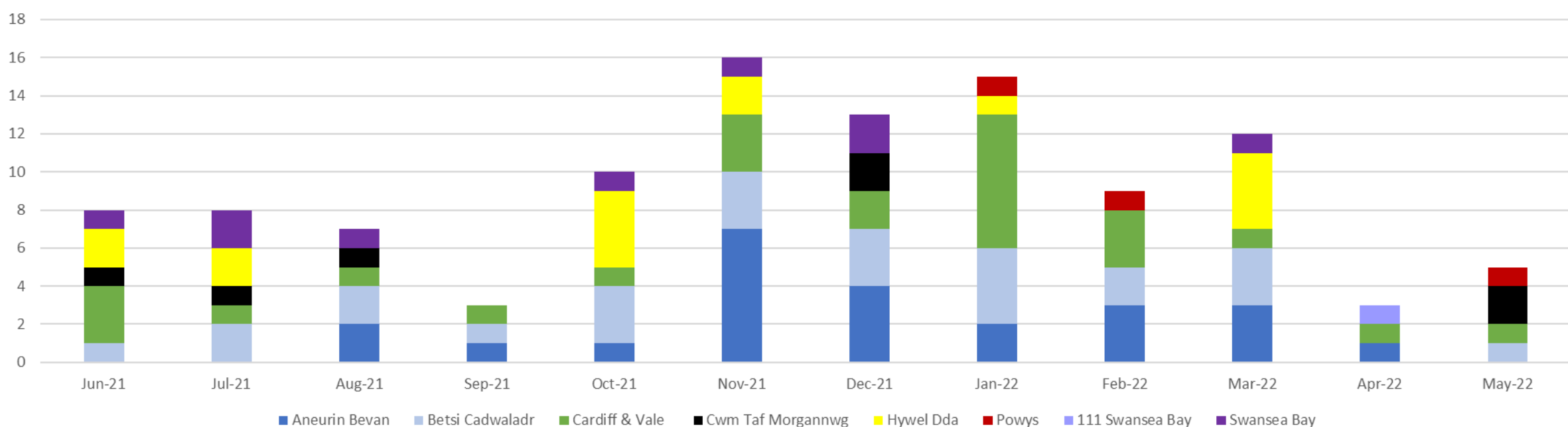
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Standard
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****NB: June 2022 data not yet available for reporting**

Volume of RIDDOR Reports by Month



Volume of Riddor Reports by Health Board



Analysis

Whilst there is a strong level of internal control with respect to GL1 Metrics provided to the Health & Safety Executive (HSE), there are moderate levels of internal control. Challenges around obtaining staff details are impacting on timeliness of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDORS) to the Health and Safety Executive (HSE). During Quarter 4 (January - March 2022) there were no fines, prosecutions, HSE improvement or Prohibition notices.

In May 2022 RIDDORS reported were for ABUHB (1), BCUHB (1), CVUHB (1), CTMUHB (2) and PHB (1).

Remedial Plans and Actions

Some members of the Health & Safety Team have been granted authorisation to access details from the Electronic Staff Record (ESR) which will provide timely access to key details in relation to RIDDOR reporting. However, one key member responsible for reporting of RIDDORS left the organisation in November 2021. Additionally, the Regional H&S Manager also responsible for reporting is on long terms sickness absence.

The Trust's compliance with Health and Safety legislation requires further work to specify and detail areas to improve compliance. A draft transformation plan has been approved by EMT endorsing the commencement of this comprehensive holistic action plan, through a Working Safely Programme.

Expected Performance Trajectory

The Trust continues to work towards improving internal controls and the timeliness of reporting RIDDORS.

The Trust has recently agreed (and funded) a new structure for the Health & Safety Team, which is currently being recruited into, whilst a clear programme of work exists for reviewing and updating policies and procedures.

****NB: May 2022 data is correct on the date and time it was extracted; therefore, these figures are subject to change**

NB: June 2022 RIDDOR data unavailable at time of reporting.

Data source: Datix



(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust



Our Patients: Quality, Safety & Patient Experience

Corporate Risk Indicators

Self Assessment: Strength
of Internal Control:
Moderate - Strong

See
Table

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Standard
- GLA3

Currently unable to report - Slide Under Review

NB: Next Update (April- June 2022) due July 2022

Data source: Electronic Risk Register



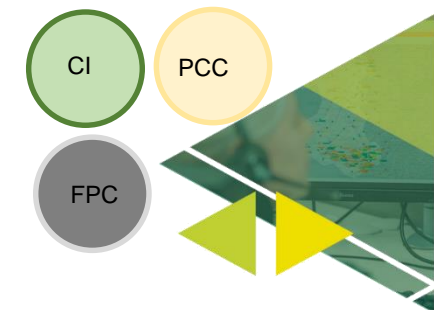
(Responsible Officer: Wendy Herbert)

Welsh Ambulance Services NHS Trust

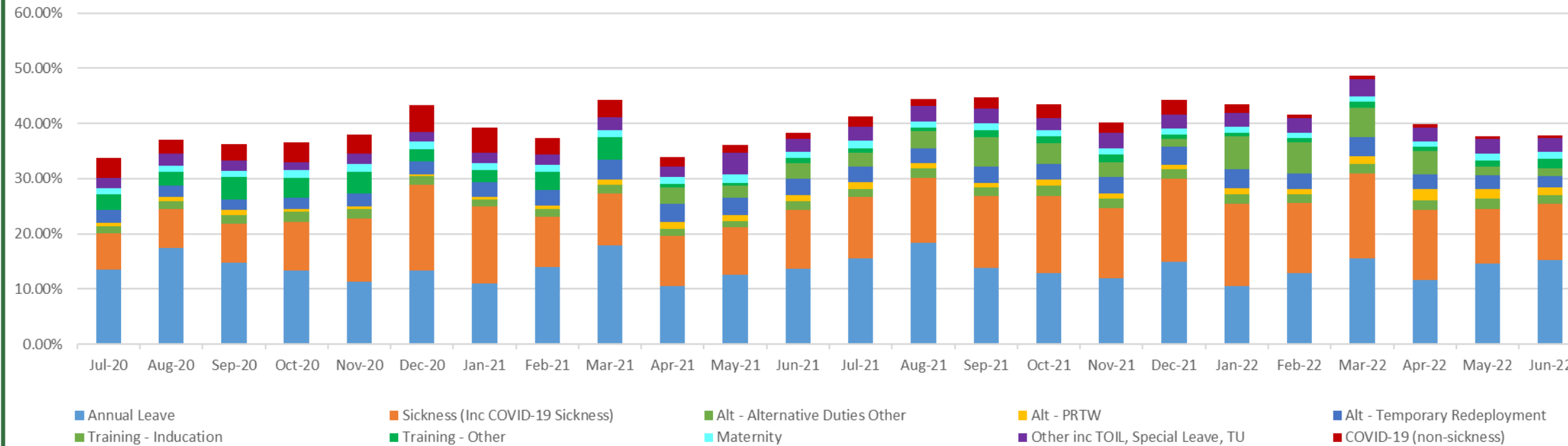


Our People

Ambulance Abstractions and Production Indicators



Pan Wales EMS Total Rota Abstraction Hours



Analysis

As shown in the top graph, monthly abstractions from the rosters are key to managing the number of hours the Trust has produced. In June 2022, total abstractions stood at 37.90%. This compares to a benchmark set in the Demand & Capacity Review of 30% which the Trust was achieving pre-COVID-19. The highest proportion was Annual Leave at 15.30% and sickness at 10.18%. However, sickness abstractions for June 2022 were lower than the previous year (10.74%) however, COVID-19 (non-sickness) related abstractions decreased in June 2022 when compared to June 2021 accounting for 0.49% of overall abstractions.

Emergency Ambulance Unit Hours Production (UHP) was 93% in June 2022 (75,096 Actual Hours), falling short of the 95% benchmark. RRV UHP achieved 79% (16,178 Actual Hours) compared to 80% in May 2022. The total hours produced is a key metric for patient safety (included on slide 7 red performance). In June 2022 the Trust produced 100,407 hours, but the graph shows that even despite significant funding for increased substantive numbers of staff, total hour produced has not risen sustainably.

Remedial Plans and Actions

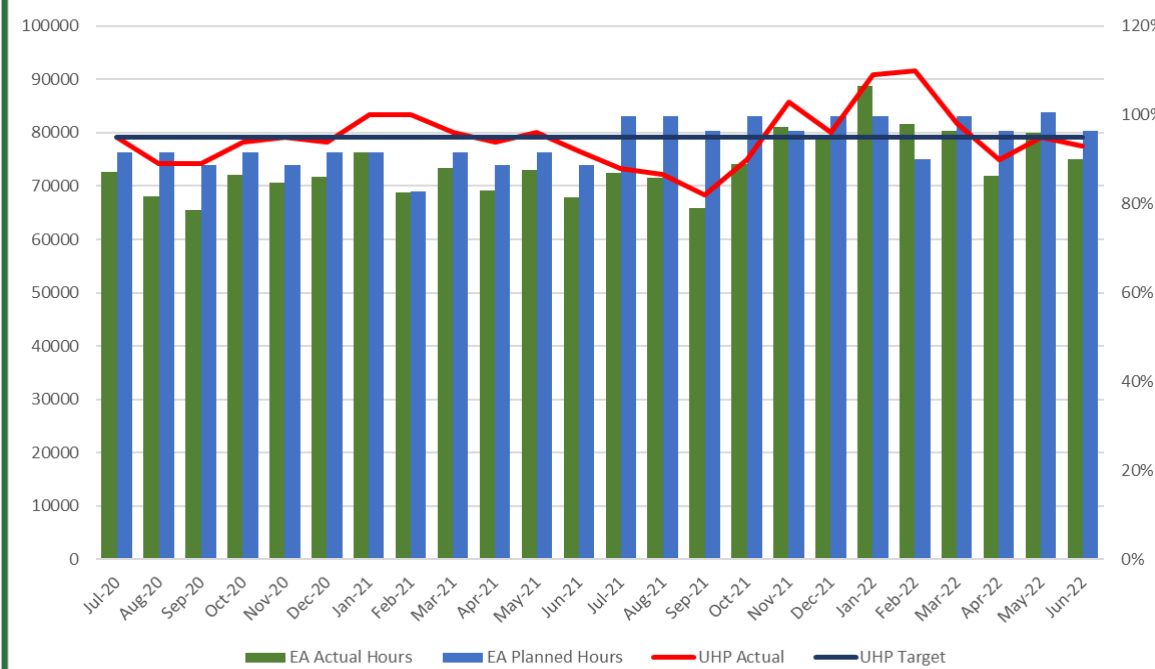
The EMS Demand & Capacity Review benchmark for GRS sickness absence abstractions is 5.99%. A new formal programme of work has commenced to review and take action to reduce sickness absence / alternative duties, which is reported into EMT every two weeks. In future months, we will include a graph in this pack of performance against the agreed trajectory/

The key actions to maximise production will continue to be the EMS Demand & Capacity Review with an additional 100 WTE to be recruited this year.

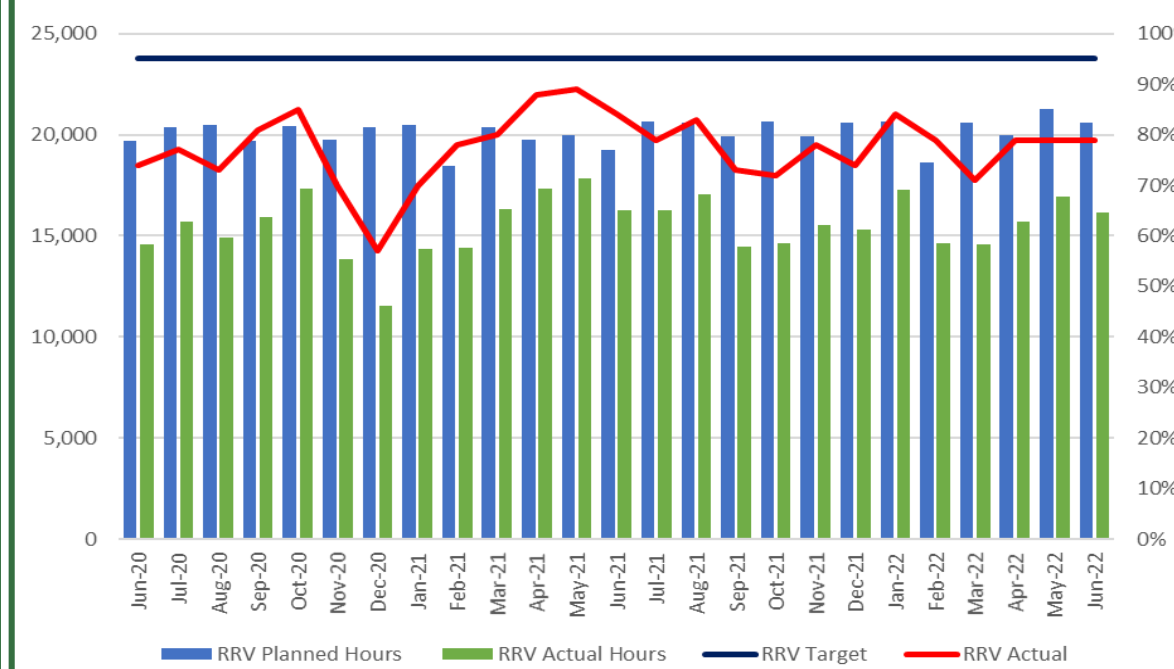
Expected Performance Trajectory

Subject to the longer-term impact of COVID-19 the benchmark is a UHP of 95% across the Trust's three main resource types and an abstraction rate of 30%. The Trust is proposed, as part of the Transition Plan, that a higher level of abstractions (and relief) is used.

Emergency Ambulance Unit Hours Production

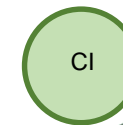


RRV Hours Planned vs Actual



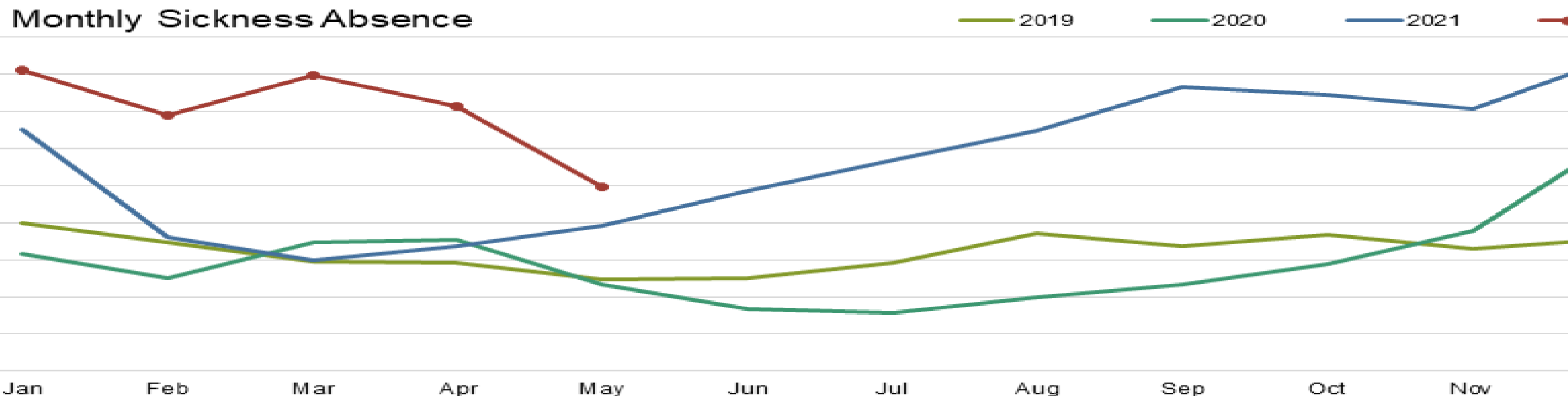


Our People Sickness Absence Indicators



NB: April 2022 / Update not available

Monthly Sickness Absence



Analysis

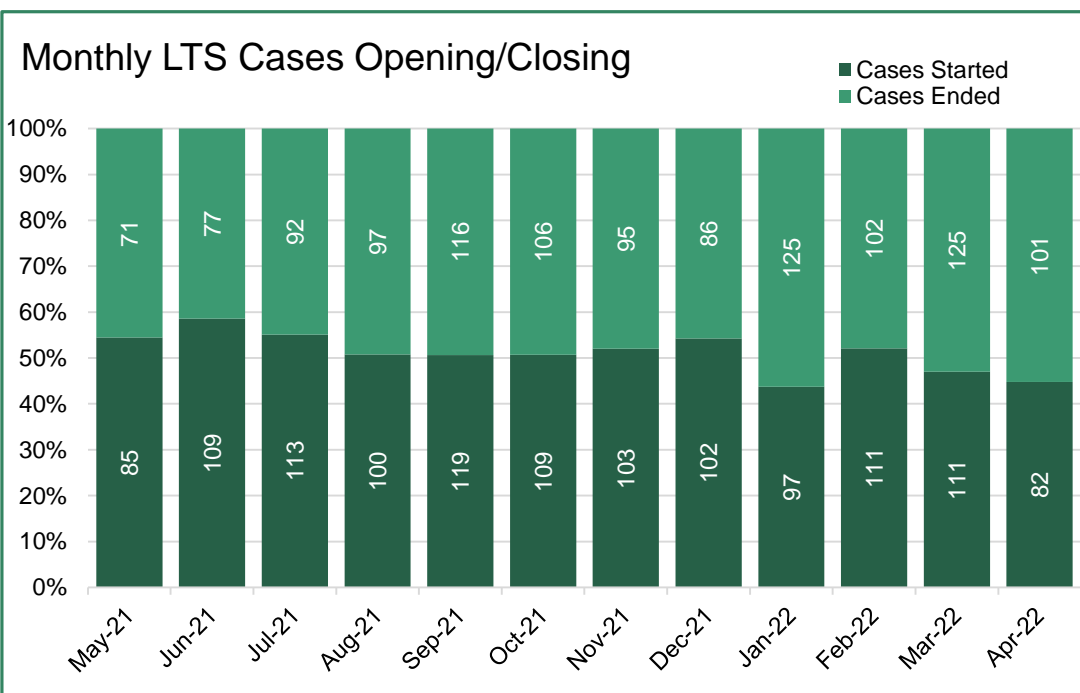
The monthly sickness absence figure for April 2022 was 11.14%, a decrease of 0.84% from last month; however, sickness levels remain the highest recorded in a 5 year period with increases in both short term and long term absence.

Remedial Plans and Actions

Physiotherapy referrals slightly increased to 31 referrals for this month, with 45% off work at time of referral. Majority of referrals were for back symptoms, closely followed by shoulder issues. Referrals to our EAP decreased against February at 72 calls. 10 of these calls were for legal concerns which is a large increase in this area.

Expected Performance Trajectory

The Trust is aware that some staff may need more time to recover due to Long-CoVID and may require a longer phased return to work alongside putting in place other supporting mechanisms. Work is also ongoing to consider the mental health aspects of COVID-19 and working from home and the Trust is actively seeking ways to consider the possibility of hidden health and wellbeing issues. It is therefore difficult to forecast or predict performance against this indicator, but the expectation is that the target is unlikely to be achieved in this financial year.



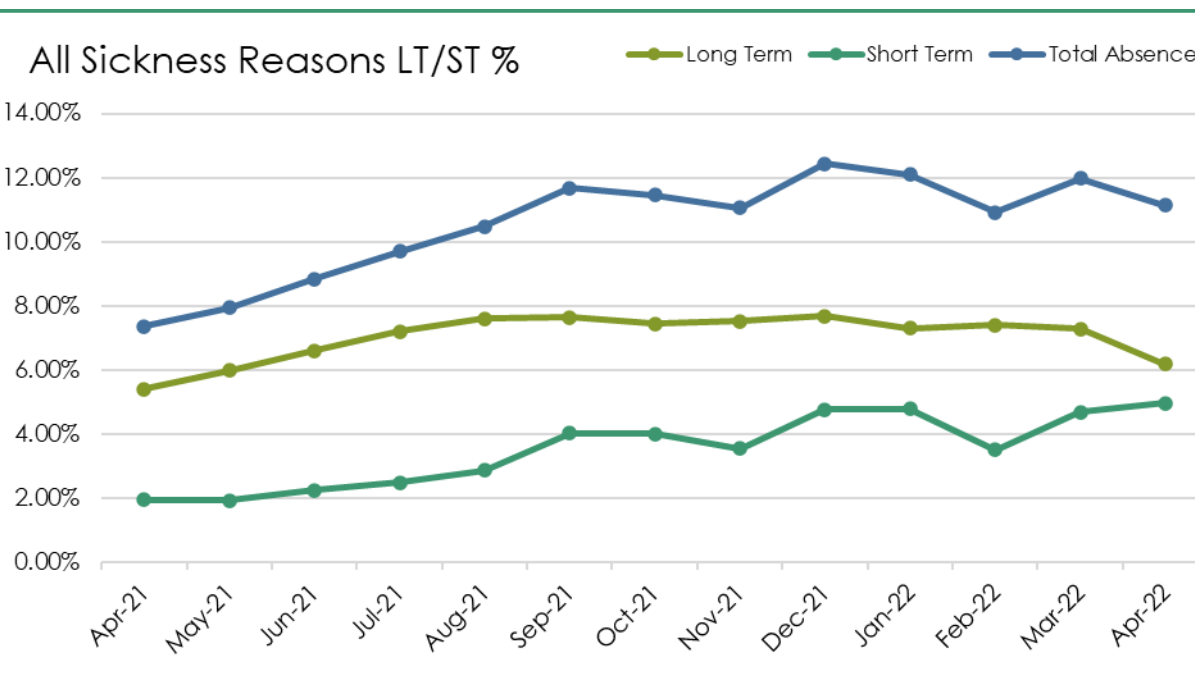
Average working days lost per FTE (Annual)

24.68 days

Single month Absence %

11.14%

Long Term	Short Term
6.18%	4.96%
Mental Health	Other MSK
2.47% <small>(S10 Stress/Anxiety)</small>	1.26% <small>(excluding Back)</small>



(Responsible Officer: Catherine Goodwin)

Welsh Ambulance Services NHS Trust



Our People Staff Vaccination Indicators

NB: April 2022 COVID-19 Vaccine Data not Available

Self Assessment:
Strength of Internal
Control: Moderate

Flu
R

CI

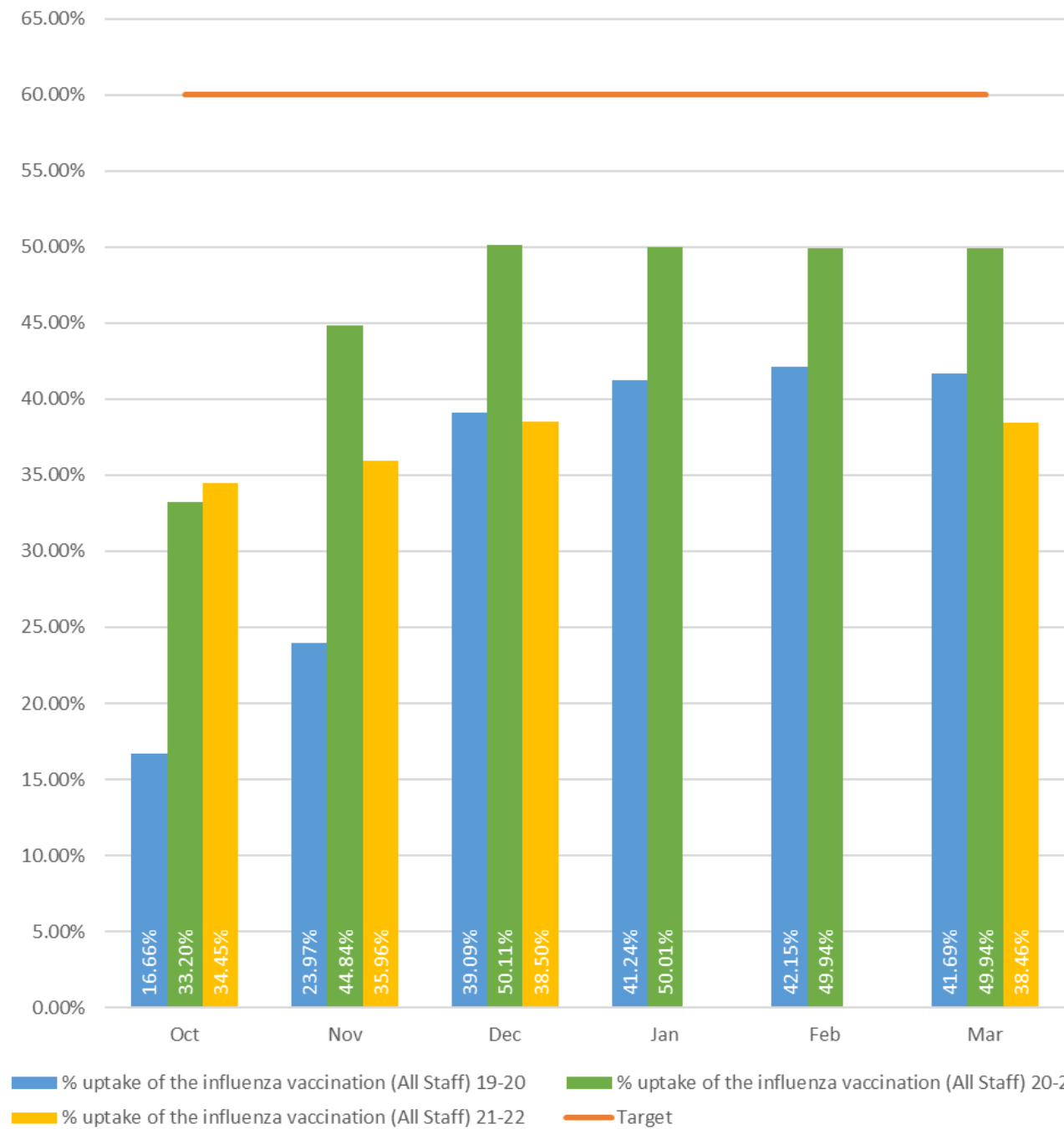
PCC

Health & Care
Standard
- Health (PPI)

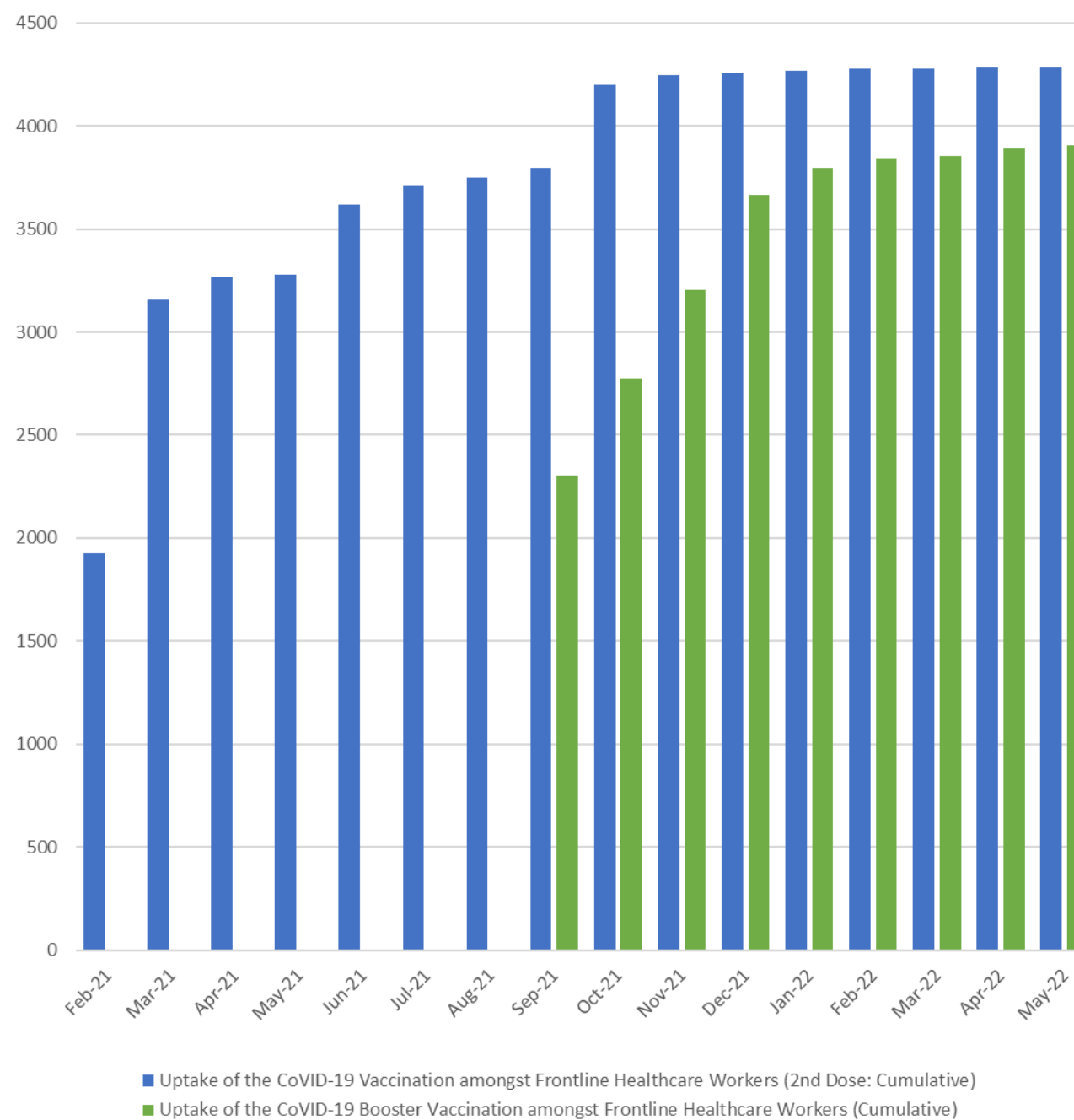
NB: Next Reporting Flu Campaign October 2022

NB: June 2022 vaccine data unavailable at time of reporting.

% Uptake of the Influenza Vaccination amongst Healthcare Workers who have Direct Patient Contact



Uptake of the CoVID-19 Vaccination Programme Amongst Frontline Healthcare Workers (Cumulative)



Analysis
The 2021-22 flu campaign got underway in Oct-21 and has now concluded; as indicated in the graph to the left 38.46% of EMS (response) and NEPTS staff received a vaccination, therefore not achieving the 60% target.

Due to a technical error in the downloading of data for the Trust are unable to report monthly data for January & February 2022.

Of the 4,532 staff currently employed (All staff) front line (Patient Facing and Non-Patient Facing staff), 95% of staff have received a first dose COVID-19 vaccination, 95% (4,283) have received a second dose and 86% (3,907 Staff) have received a booster vaccination. In addition 94% of volunteers have received a first dose vaccination, 93% have received a 2nd dose and 88% have received a booster vaccination.

Remedial Plans and Actions
Staff data has been refreshed to accurately staff numbers employed by WAST.

Expected Performance Trajectory
An evaluation of the 2021-22 flu campaign is currently being completed. Early indications from the southern hemisphere are that there has been more flu in their winter. The Trust is currently developing forecasts for the winter period that build in CoVID-19 and flu..

Date source: Cohort Electronic System / Welsh Immunisation System (WIS)



Our People

PADR and Training Rates Indicators

R

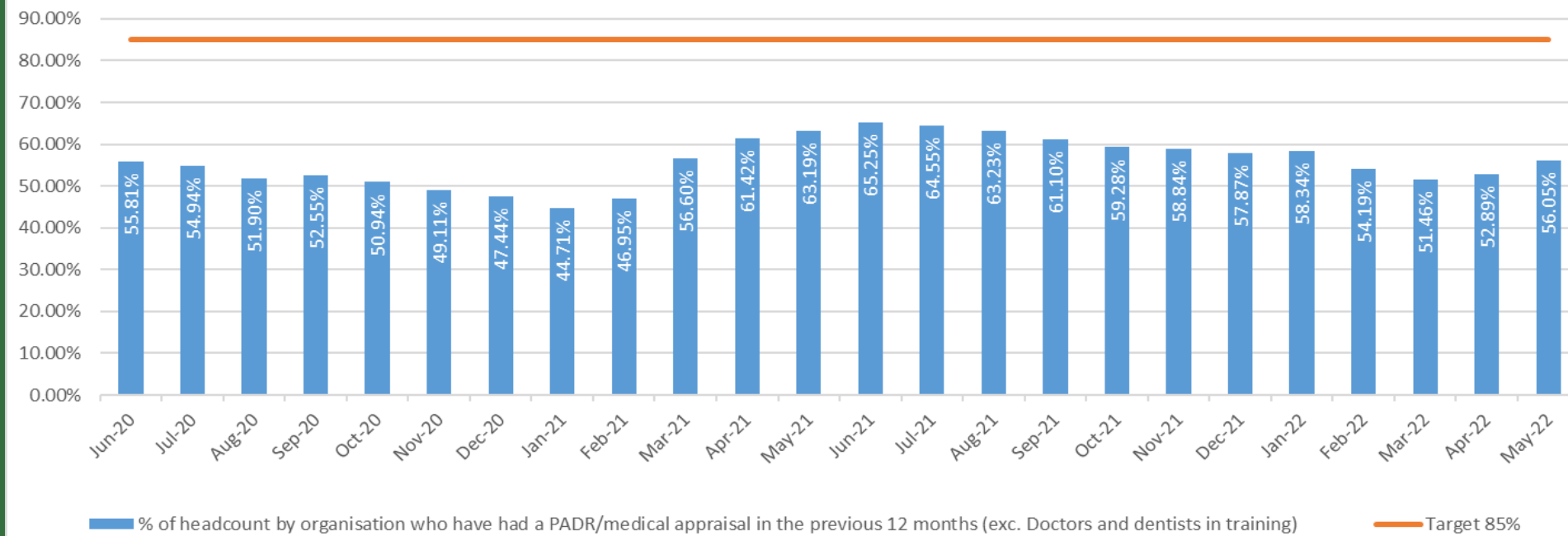
Self Assessment:
Strength of Internal
Control: Strong

CI

PCC

Health & Care
Standard
Health – Staff &
Resources

% of headcount by organisation who have had a PADR/medical appraisal in previous 12 months



Analysis

PADR rates for May 2022 improved marginally to 56.05%; however, they continue to remain well below the 85% target.

May 2022 Statutory & Mandatory Training rates increased by 0.60% from the April 2022 figure, achieving the 85% target for the first time in 22 months. Fire Safety (67.38%), and Moving & Handling (82.67%) both failed to achieve the 85% target; however, Information Governance (85.67%) and Safeguarding Adults (89.03%) achieved the target in May 2022.

In April 2022 Band 6 Paramedic Competency rates (All Staff) are 84.97% for year 1, 79.77% for year 2 and 74.59% for year 3. These figures exclude newly qualified Paramedics and staff on Long-Term Sickness and Maternity. Of the original Band 6 paramedic cohort, the rates are 100% for year 1, 100% for Year 2 and 100% for year 3. *No update provided*

Skills and Training Framework	NHS Wales Minimum Renewal Standard
Equality, Diversity & Human Rights (Treat me Fairly)	3 years
Fire Safety	2 years
Health, Safety & Welfare	3 years
Infection Prevention & Control - Level 1	3 years
Information Governance (Wales)	2 years
Moving and Handling - Level 1	2 years
Resuscitation - Level 1	3 years
Safeguarding Adults - Level 1	3 years
Safeguarding Children - Level 1	3 years
Violence & Aggression (Wales) - Module A	No renewal
Mandatory Courses	
Violence Against Women, Domestic Abuse and Sexual Violence	3 years
Dementia Awareness	No renewal
Environment, Waste and Energy (Admin & Clerical staff Only)	Yearly

There are currently 2 (13 for Admin & Clerical Staff) Statutory and Mandatory courses that all NHS employees must complete in their employment. These are listed in the table to the right.

Remedial Plans and Actions

Since the onset of CoVID the Learning and Development team have moved the Trust towards a more blended model of education. All staff are actively encouraged to take ownership of their e-learning through self-identification of topics they are required to update. This is done through logging into ESR and reviewing individual compliance. Where e-learning is appropriate staff log in and complete this in a timely manner. This then negates the need for colleagues to attend classroom based CPD days where it is not necessary. CPD is supported by the ESR Team and user guides, and other supportive information is available through the WAST intranet and via Yammer.

Targeted communication via Siren and Yammer will continue using the #WASTMakItHappen tagline to reinvigorate My Learning on ESR for Corporate Compliance will continue. In addition, meetings are ongoing with the Ambulance Response Team to highlight compliance rates for Frontline staff and continue to monitor.

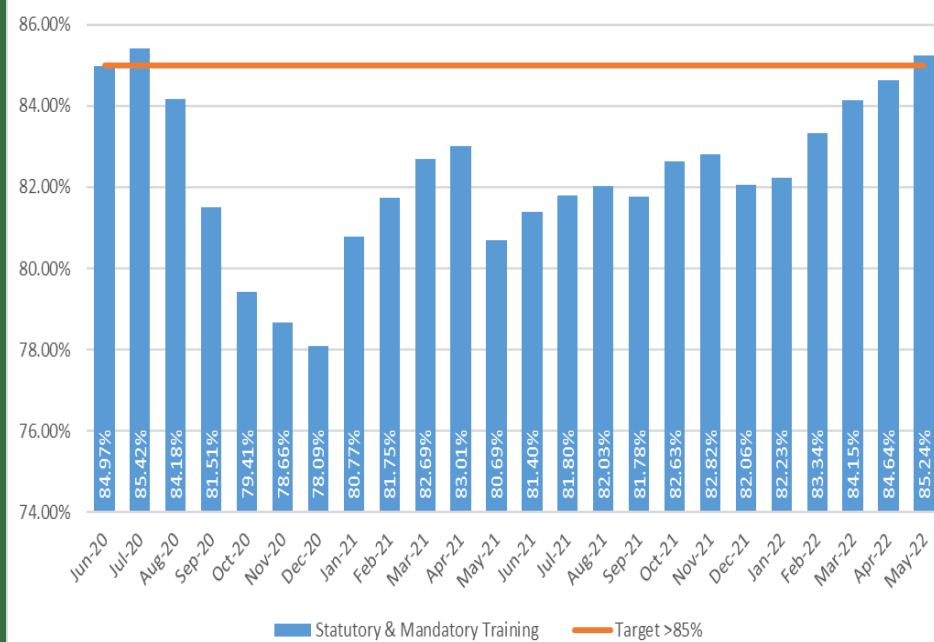
Expected Performance Trajectory

Uptake in the e-learning based topics continues to be very positive and staff of all grades have embraced the concept and are engaged with this new concept. Staff seem to have bought into the "new normal" and the Trust expects to continue to see improving compliance figures across the Trust.

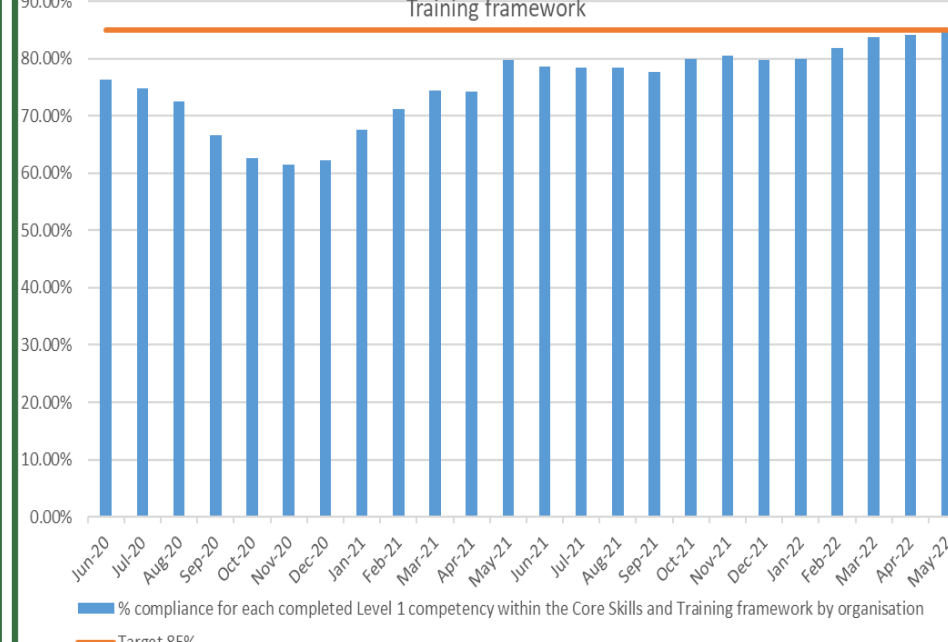
NB: June 2022 data unavailable at time of reporting.

Data source: ESR

% Compliance Statutory and Mandatory Training (10 CSTF Modules)



% compliance for each completed Level 1 competency within Core Skills & Training framework

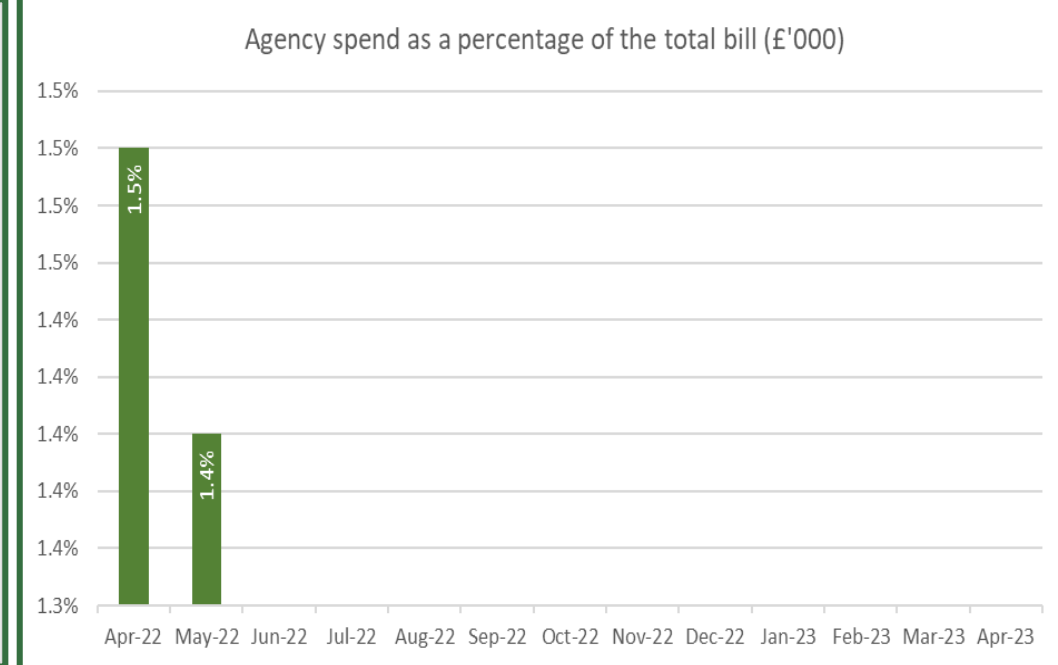
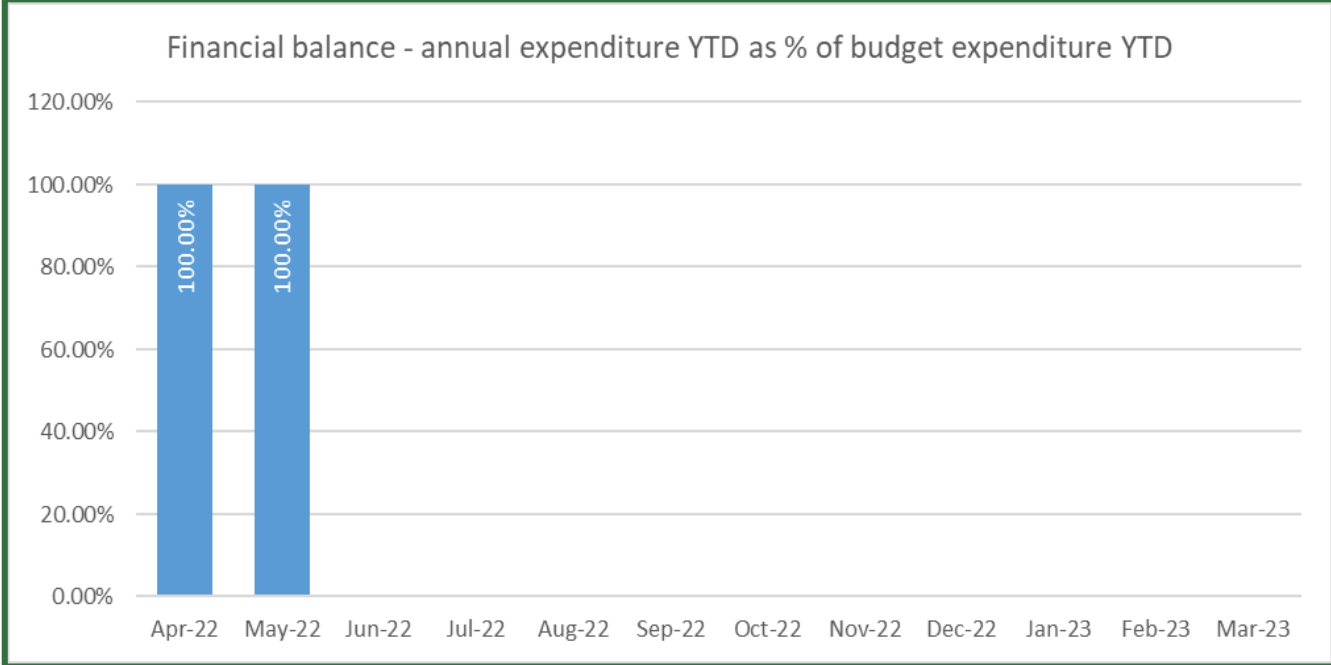




Finance and Value Finance Indicators



NB: June 2022 data unavailable at time of reporting.



Analysis

The reported outturn performance at month 2 is a surplus of £4,000, with a forecast to the yearend of breakeven.

For month 2 the Trust is reporting planned savings of £0.716m and actual savings of £0.664m, an achievement rate of 92.7%.

Cumulative performance against the Public Sector Purchase Programme (PSP) as of May 2022 was 96.8% against a target of 95%.

As of May 2022, the Trust is forecasting achievement of both its External Financing Limit and its Capital Resource Limit.

Remedial Plans and Actions

The Trust's financial plan for 2022-25 will build on the plans and financial performance of the last few financial years, in which the Trust has, year on year, achieved financial balance; the 2022-25 financial plan was submitted to WG following Board sign off on 31st March 2022.

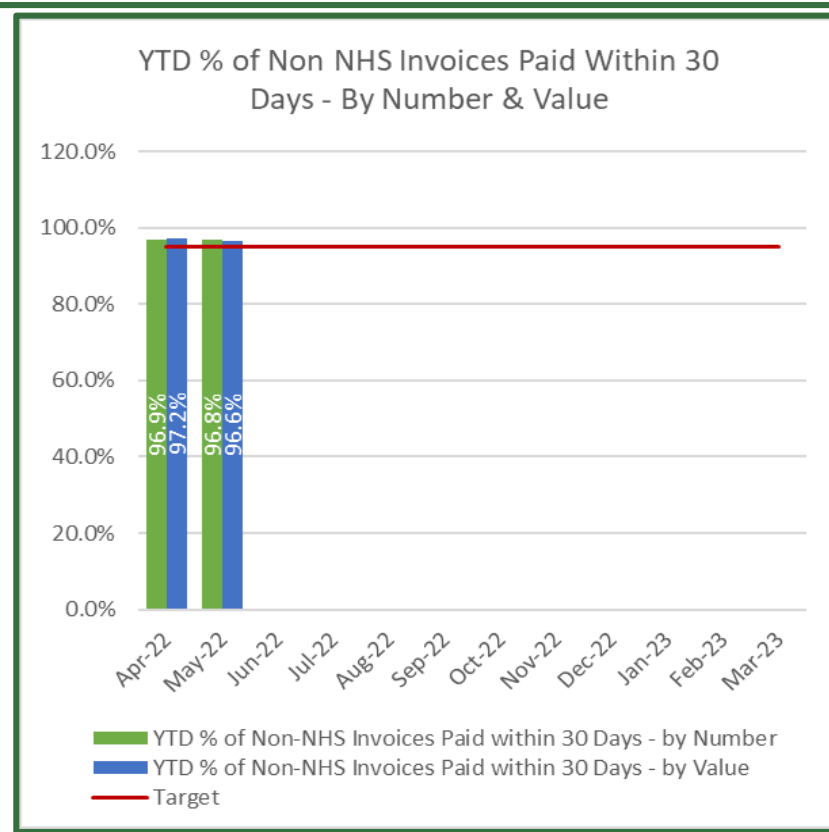
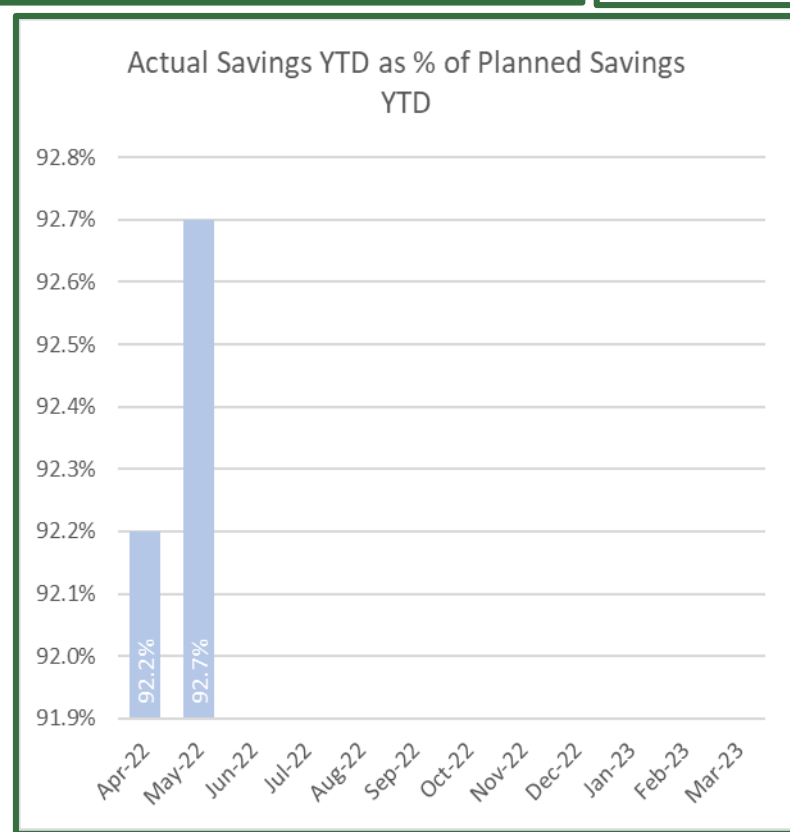
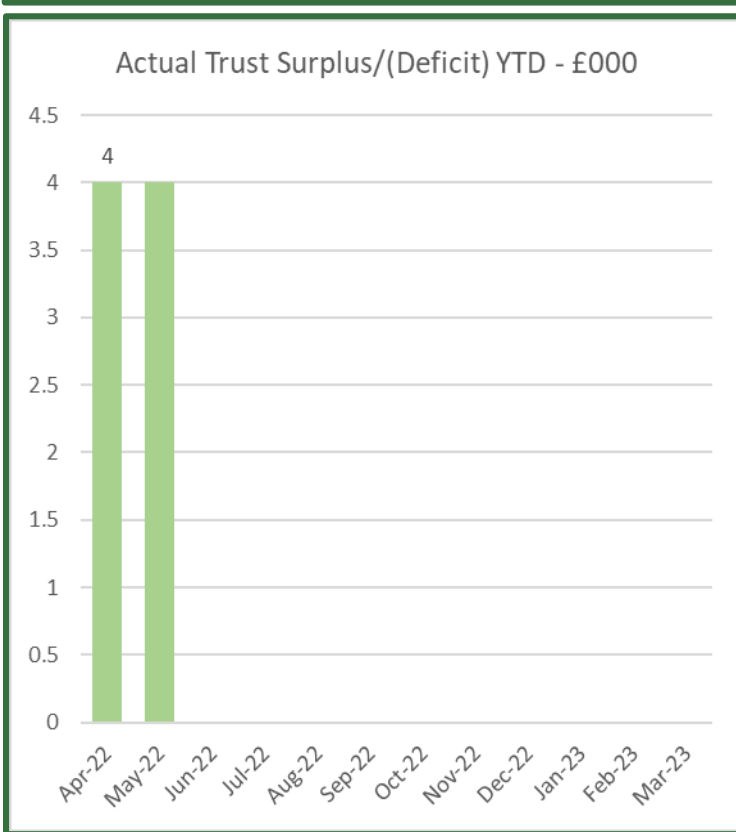
No financial plan is risk free. Financial risk management forms a key element of the project plans which underpin both the Trust's ambitions and savings targets. The Trust continues to seek to strengthen where it can its financial capacity and corporate focus on finance, and as an organisation have structures in place to drive through the delivery of our financial plan.

Key specific risks to the delivery of the 2022/23 financial plan include:

- Continuing financial support from Welsh Government in relation to Covid costs;
- Availability of capital funding to support the infrastructure investment required to implement service change, and the ability of the Trust to deliver the revenue consequences of capital schemes within stated resource envelope;
- Financial impact of EASC Commissioning Intentions, and confirmation of the EMS financial resource envelope as assumed within our financial plan;
- Ensuring additional avoidable costs that impact on the Trust as a result of service changes elsewhere in the NHS Wales system are fully recognised and funded;
- Ensuring any further developments are only implemented once additional funding to support these is confirmed;
- Delivery of cash releasing savings and efficiencies;

Expected Performance Trajectory

The expectation is that the Trust will continue to meet its statutory financial duties, as outlined in its IMTP; however, it is expected that the Trust will continue to operate in a challenging financial environment and will need to continue to deliver further planned savings into 2022/23.



(Responsible Officer: Chris Turley)

Welsh Ambulance Services NHS Trust



Value / Partnerships & System Contribution

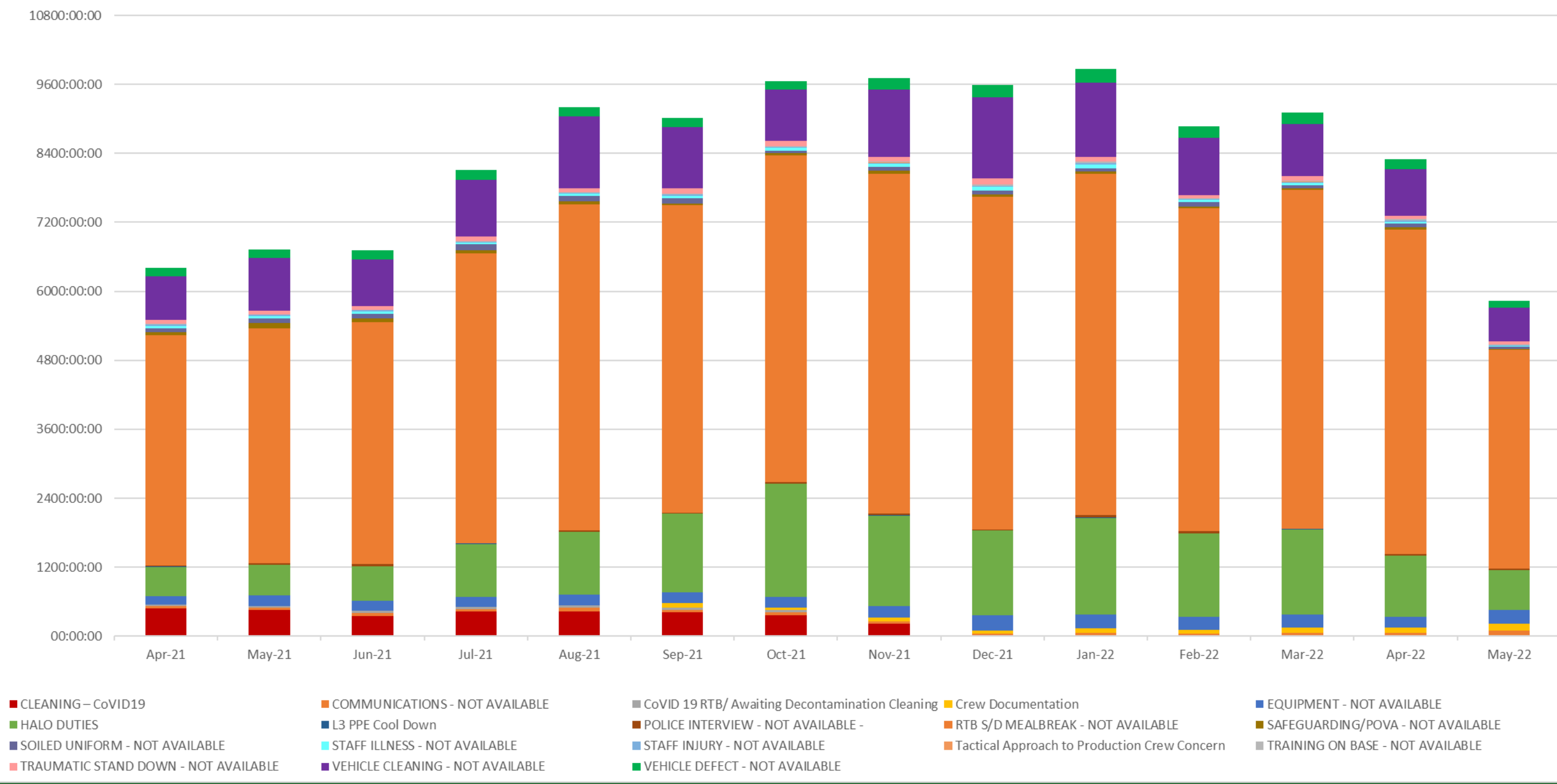
EMS Utilisation & Post Production Lost Hours Indicators



NB: Revised data reported based on amendments in QlikSense and refinements applied to improve accuracy in reporting

NB: June 2022 data not yet available

Post Production Lost Hours - By Unavailability Reason (EA, RRV & UCS)



Analysis

There were 5,835 post production lost hours (PPLH) across EA, RRV 7 UCS vehicles in May 2022; a decrease when compared to April 2022 (8,292).

In May 2022 hours lost through PPLH can be down to numerous factors, including, but not limited to Return to Base, Meal Breaks (3,795 Hours), HALO duties (698 hours) and Vehicle Cleaning (586 Hours). It can also be as a result of different processes at hospital sites causing variation in process in flow throughout the system that contribute towards post-production lost hours.

Remedial Plans and Actions

This is currently an area of focus via a series of workshops with TU Partners.

Expected Performance Trajectory

The current data needs to be treated with a degree of caution, for example, there are good reasons for some post production lost hours, plus there are issues of data entry. The Trust has recently undertaken more benchmarking on PPLHs which suggests that it compares favorably with two other ambulance services, but less so with a third. Contact is being sought with this third service. A deep dive on PPLH is going to May-22 F&P Committee.

****NB: PPLH Data correct at time of extract**



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust



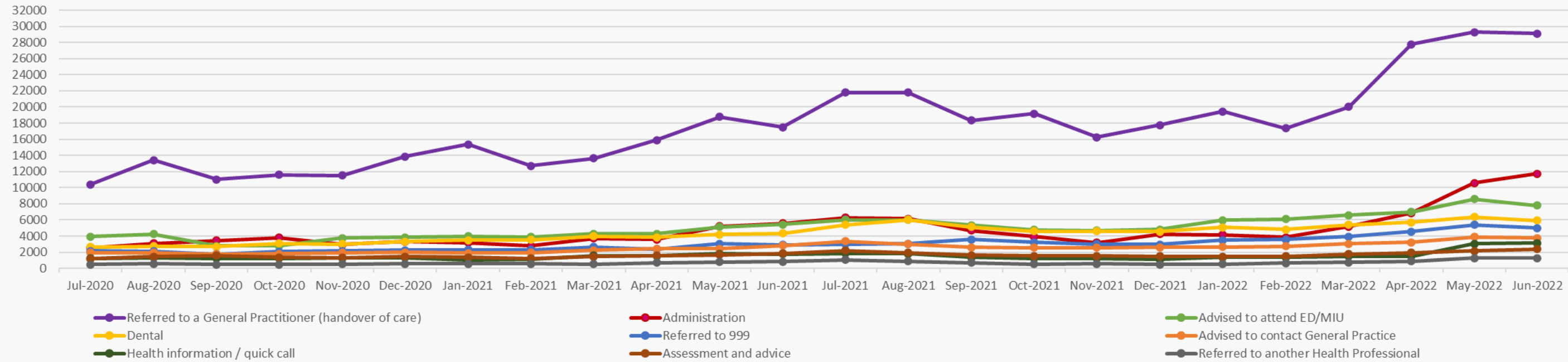
Our Patients: Quality, Safety & Patient Experience

111 Hand Off Metrics and 111 Consult & Close Indicators

Influencing Factors – Demand and Clinical Hours Produced



111 Calls By Final outcome



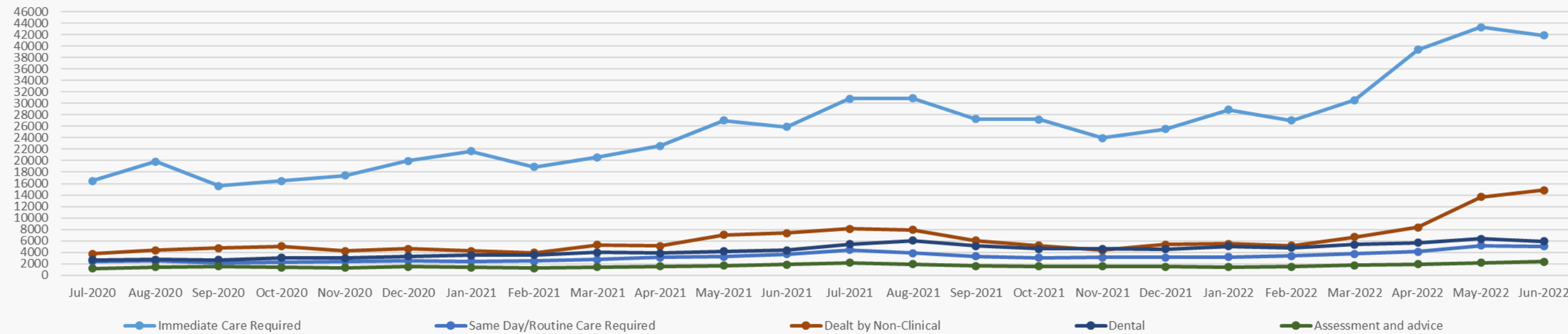
Analysis

In June 2022 calls Referred to General Practitioner (handover of care) continued to be the top outcome for NHS111 accounting for 42% of calls.

Calls falling in the Immediate Care Required category saw the highest volume; this includes calls referred to General Practitioner (29,082), Administration (11,714), and advised to attend ED/MIU (7,770).

In June 2022 70,039 calls were received in the 9 categories displayed in the top graph, an increase when compared to 70,645 in May 2022; 26,202 in June 2020 and 43,067 in June 2021.

111 Calls by Final Outcome



Remedial Plans and Actions

Work is underway to develop live informatics which provide real time information on clinician availability to allow improved understanding and management; this will enable the Trust to report more meaningful metrics and accurately monitor patient outcomes.

Expected Performance Trajectory

A Contract Analyst is currently undertaking work to improve 111 data metrics available; this will allow us to report more meaningful and relevant data in relation to whether patients are directed to the most appropriate and best outcomes.



(Responsible Officer: Lee Brooks)

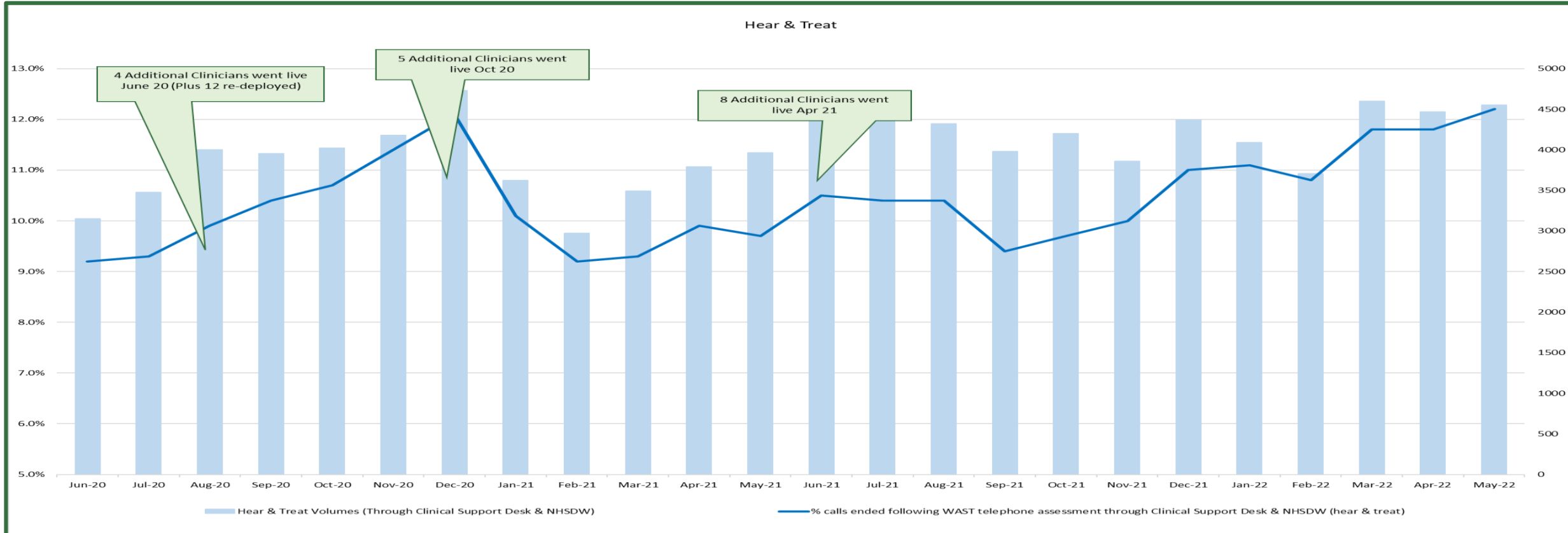
Welsh Ambulance Services NHS Trust



Partnerships / System Contribution Consult & Close Indicators



NB: June 2022 data unavailable at time of reporting.



Analysis

The **Clinical Service Desk (CSD)** and **NHSDW (Hear & Treat)** achieved 12.2% performance in May 2022, therefore continuing to achieve the 10.2% target for the seventh consecutive month.

9.1% of hear & treat volumes were achieved by the CSD in May 2022. In comparison, 3.1% of hear & treat was by NHS111.

The percentage of re-contacts within 24 hours of telephone hear and treat has fluctuated over the last two years, peaking in Jun-20 to 15.7%.

Re-contact rates in May 2022 were 7.4% a decrease compared to 9.2% in April 2022, however, this is an increase compared to 4.7% in May 2021.

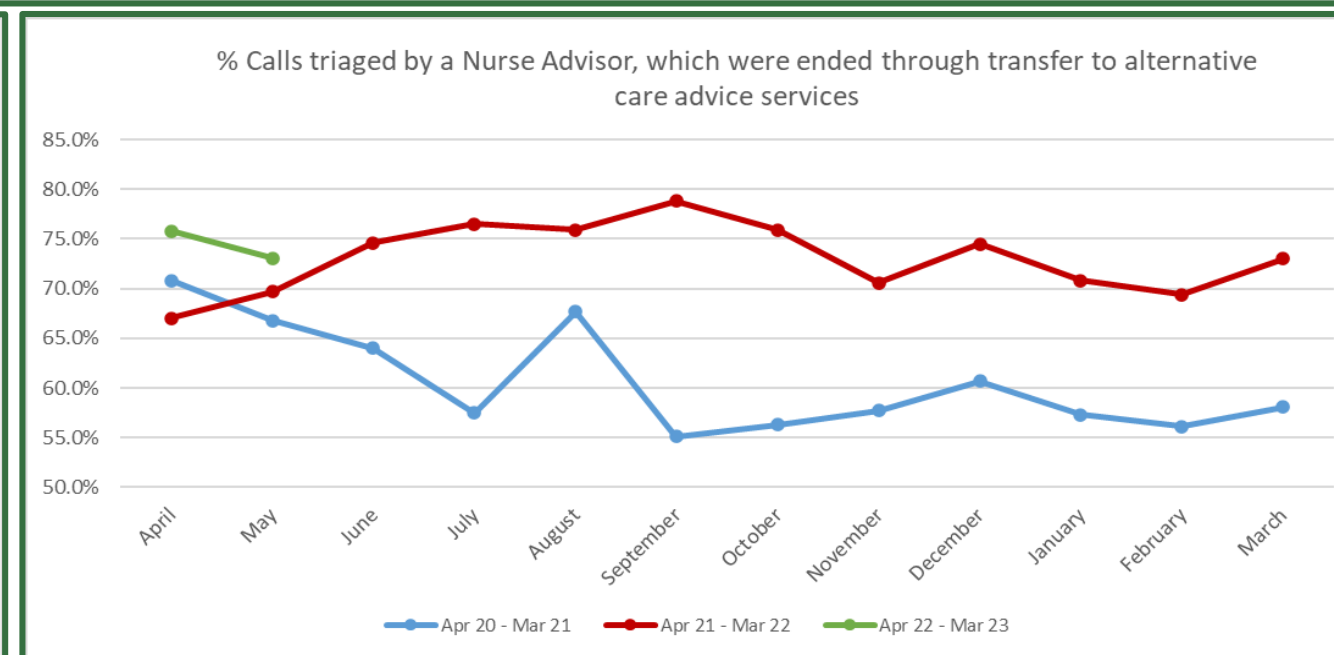
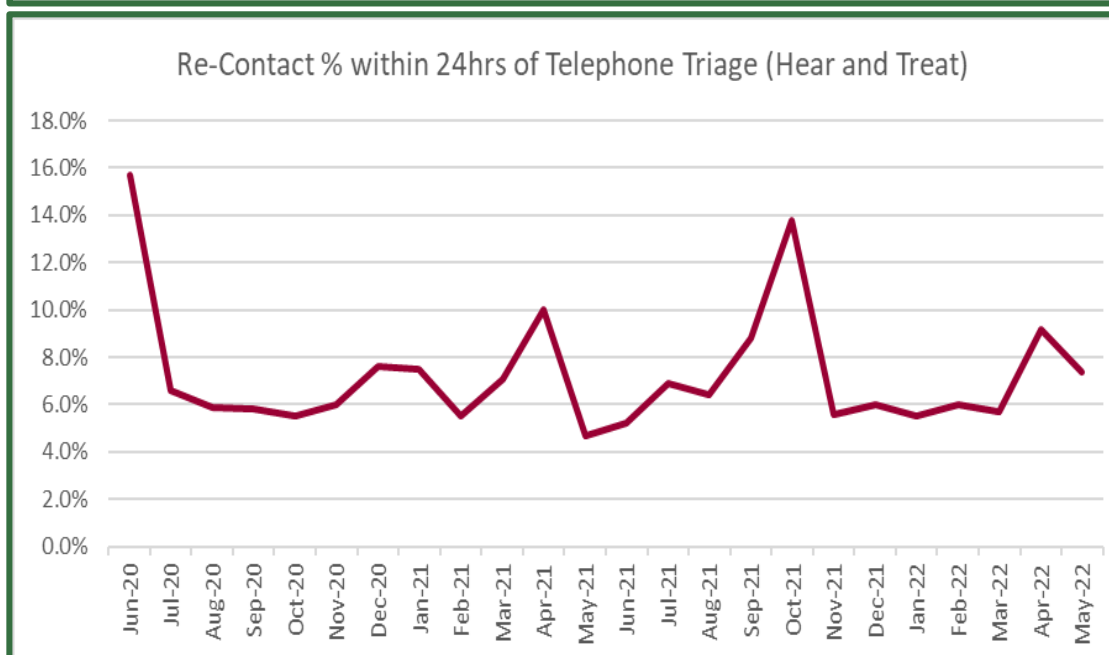
The percentage of calls triaged by nurse advisor ended through transfer of alternative care advice services increased month on month to 73.1% in May 2022; by comparison, this figure was 69.7% in May 2021.

Remedial Plans and Actions

- Funding has been agreed to double the size of the CSD, including introduction of 5 mental health practitioners. In the first few months of the year, the staff have been onboarded and have been training on the new ECNS system. It is likely therefore that we will start to see the full effect into Q2 / Q3
- The team are also undertaking detailed process maps of the work that they do in order to identify where improvements can be made
- The revised establishment is 96 FTEs with current in post 90 FTEs.

Expected Performance Trajectory

The current target for this year is 15% hear and treat rate for 2022/23 as part of the development of the 2022-25 IMTP and associated forecasting and modelling. We would hope to be achieving this in the second half of the year



(Responsible Officer: Lee Brooks)

Welsh Ambulance Services NHS Trust

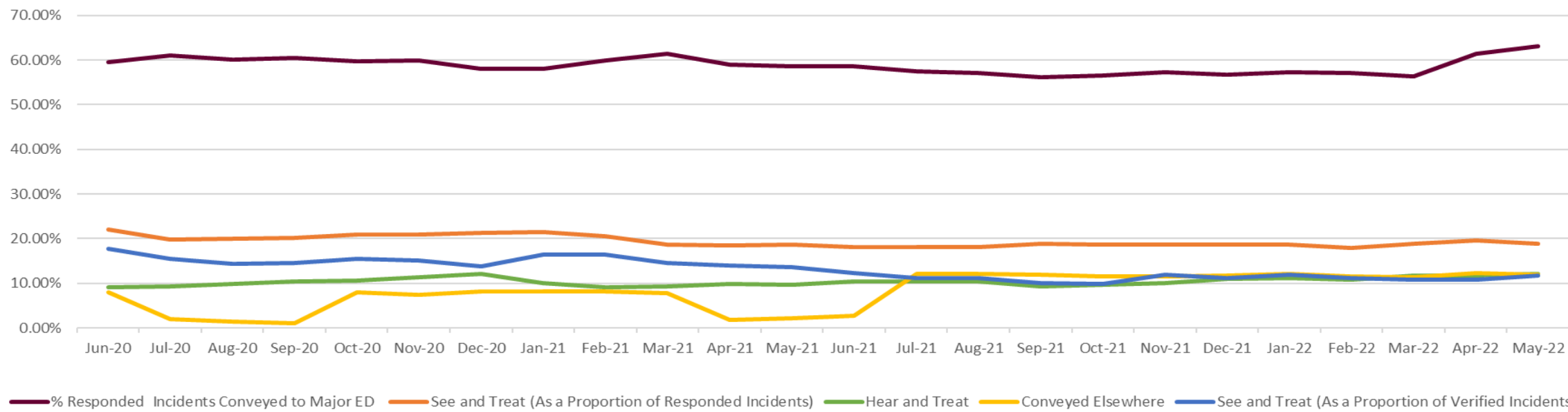


Partnerships / System Contribution Conveyance to ED Indicators



NB: June 2022 Conveyance and Incidents data unavailable at time of reporting.

% of Patients Conveyed to Major ED, Triaged through Hear or See and Treat or Conveyed Elsewhere



Analysis

The percentage of patients conveyed to EDs decreased (i.e. improved) compared to the same period last year. In May 2022 conveyance to EDs as a proportion of total verified incidents was 39.02% (compared to 42.54% in May 2021). In addition, 12% of patients (1,754) patients were conveyed to a service other than a Type One ED.

The combined number of incidents treated at scene and referred to alternate providers increased in May 2022 when compared to April 2022. 2,118 incidents were referred to alternative providers in May 2022 and 2,271 incidents were treated at scene; however, a review of other outcomes (see graph) shows that there are a number of incidents where there was a no send due to escalation of the Clinical Safety Plan (CSP).

In June 2022 611 ambulances were stopped due to CSP alternative transport and 242 were as a result of CSP Can't send options. In addition 11,387 ambulances were cancelled by patients (including patients refusing treatment at scene) and 367 patients made their way to hospital using their own transport.

Remedial Plans and Actions

This indicator captures the impact of all "shift left" activity, for example hear & treat, see & treat (APPs, Band 6 Paramedics), pathways and conveyance to other hospital locations e.g. minor injury units (MIUs), direct admissions etc. Years 3-5 of the EMS Operational Transformation Programme offer the potential to take a more transformative look at options for further reducing conveyance, where it is clinically safe and appropriate to do so. The initial results of this modelling are expected w/c 24 January 2022 (received).

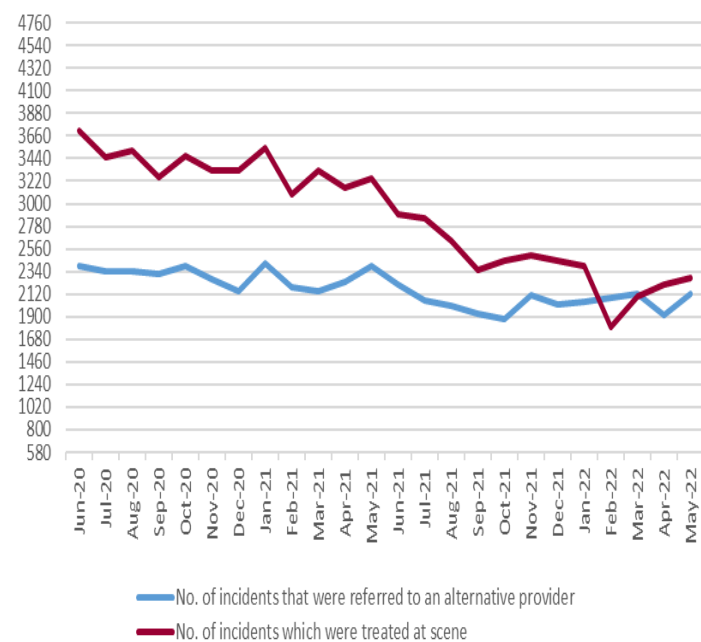
As part of the IMTP and working with partners across the health system. WAST has been asked to lead on the development of a National Respiratory work stream. A four phased proposal has been designed to deliver sustainable service level improvement for respiratory patients across Wales aligned to the national strategic direction and delivered in collaboration with Health Boards & key stakeholders: Delivery will be dependent on cooperation with health boards who will need to provide a service to refer into; however, this has the opportunity to increase referrals to alternative providers.

One of the Trust's commissioning intentions is to develop an optimising conveyance strategy, which will bring forward clearer proposals linked to further work on the EMS Demand & Capacity Review.

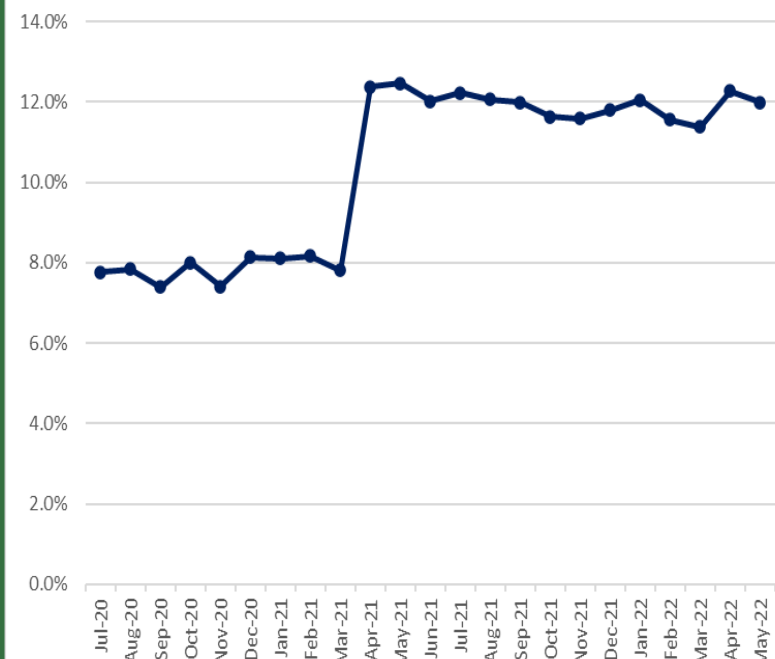
Expected Performance Trajectory

The Trust has completed modelling on a full strategic shift left, which identifies that the Trust could reduce handover levels by c.7,000 hours per month, with investment in APPs and the CSD; however, the modelling indicates that handover would still be at 10,000 hours per month. Health Board changes are required as well.

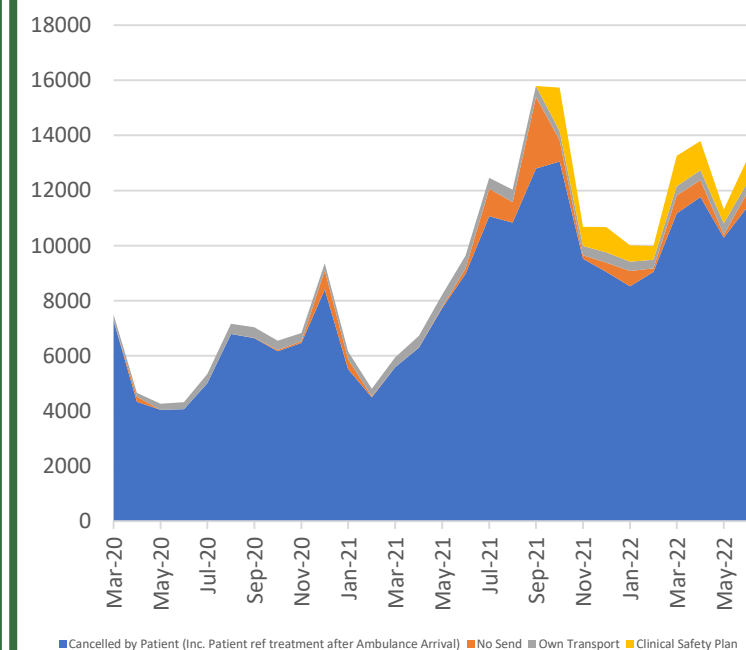
Incidents Treated at Scene VS Incidents Referred to Alternative Providers (Ambulances Stopped)



% of Total Conveyances taken to a service other than a Type One Emergency Department



Numbers of patients with no send or cancelling ambulance

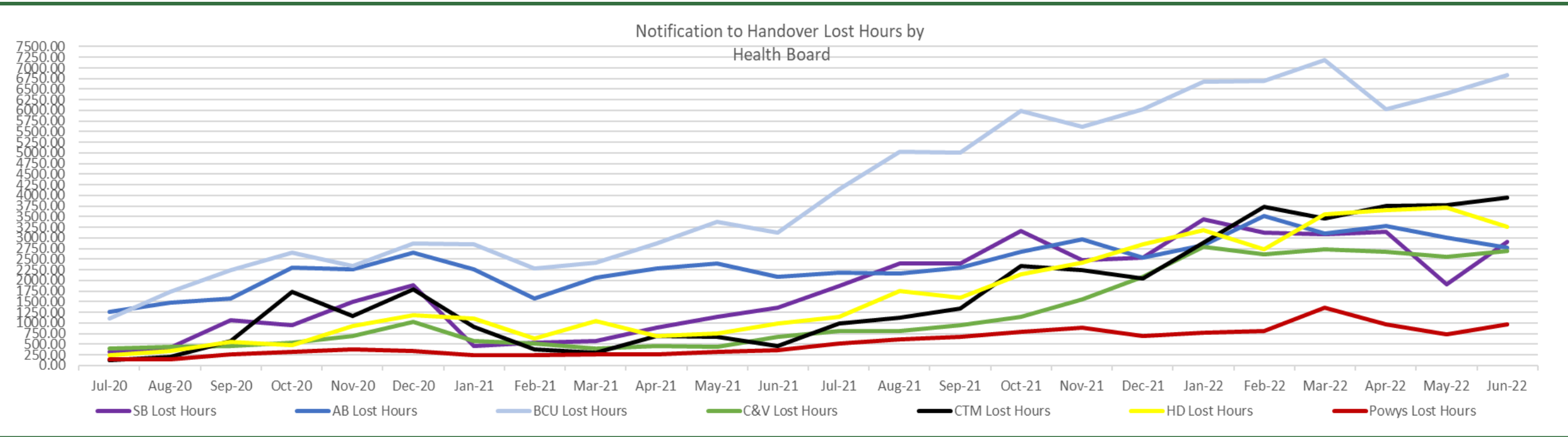


(Responsible Officer: Andy Swinburn)

Welsh Ambulance Services NHS Trust



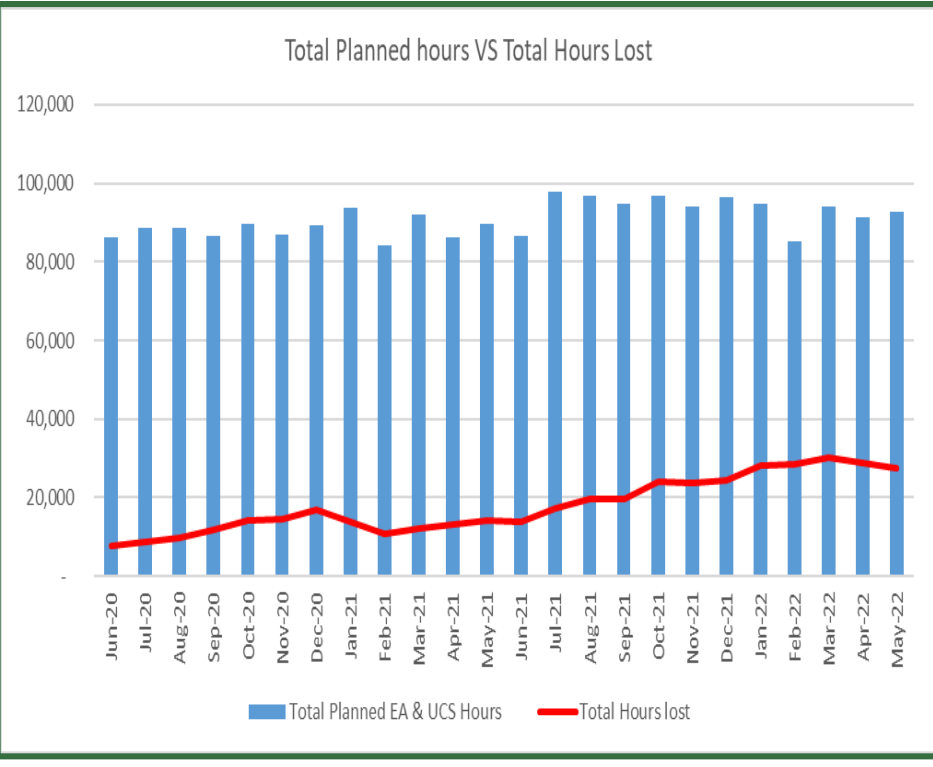
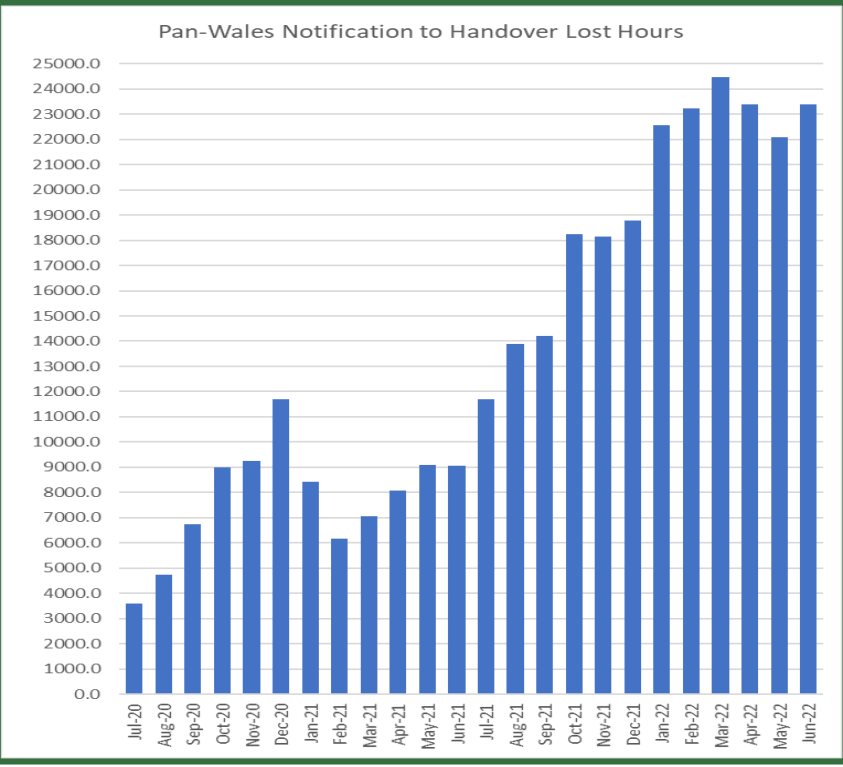
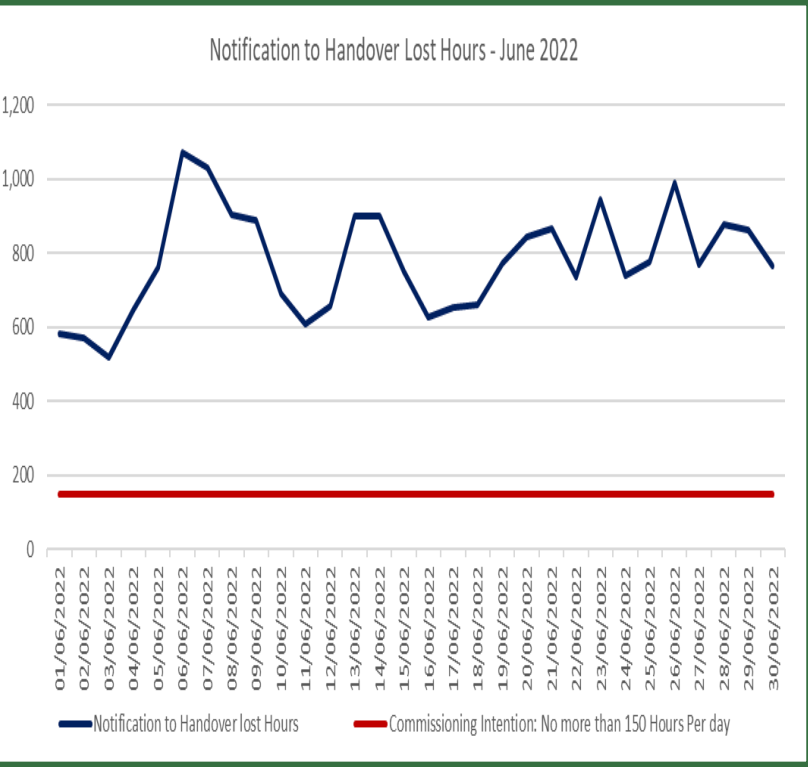
Partnerships / System Contribution Handover Indicators



Analysis
234,064 hours were lost to Notification to Handover, i.e. hospital handover delays, over the last 12 months, compared to 92,892 in same period a year ago (July 2020 to June 2021). 23,387 hours were lost in June 2022, a 50% increase compared to 9,059 lost hours in June 2021 and an increase when compared to 13,820 recorded in December 2019, the previously worst recorded month, prior to August 2021. The hospitals with highest levels of handover delays during June 2022 were Morryston Hospital (SBUHB) at 2,901 lost hours, hours University Hospital of Wales (CVUHB) at 2,603 lost hours, Glan Clwyd Hospital Bodolwyddan (BCUHB) at 2,597 lost hours, Grange University Hospital (ABUHB) at 2,452 lost and Princess of Wales Hospital (SBUHB) at 1,865 lost hours.

Notification to handover lost hours averaged 780 hours a day in June 2022, 520% higher than the commissioning intention of no more than 150 hours per day.

In June 2022 the Trust could have responded to 7,378 more patients if handovers were reduced.



Remedial Plans and Actions
 Significant time has been spent by all Executives and non-Executives highlighting this patient safety issue to EASC, Health Boards and to Welsh Government / Minister, and this will continue through the year as we seek to influence and put pressure on the system to improve.

Healthcare Inspectorate Wales (HIW) has undertaken a local review of WAST to consider the impact of ambulance waits outside Emergency Departments, on patient dignity and overall experience during the COVID-19 pandemic.

The WIIN platform continues to focus on patient handover delays at hospital and Electronic Patient Care Record (ePCR). 22 ideas have been received through the WIIN platform from staff in June 2022.

Expected Performance Trajectory
 The direction is that handover lost hours should return to 25% of their Oct-21 levels, just under 14,000 hours, that there should be no waits over 4 hours and non-release for Immediate Release Requests should become a Never Event.

Definition of Indicators

Indicator	Definition	Indicator	Definition
111 Abandoned Calls	An offered call is one which has been through the Interactive Voice Response messages and has continued to speak to a Call Handler. There are several options for the caller to self serve from the options presented in the IVR and a proportion of callers choose these options. An example is to guide the caller to 119 if they wish to speak to someone about a Coronavirus test. Once the caller is placed in the queue for the Call Handler if they hang up they are counted as “abandoned” as we did not answer the call. The threshold starts at 60 seconds after being placed into the queue as this allows the callers to respond to the messages and options presented as it often takes a short while for the caller to react. Starting the count at 60 seconds provides a picture of abandonment where the caller has chosen not to wait, despite wanting to speak to a Call Handler	Hours Produced for Emergency Ambulances	Proportion of hours produced within the calendar month for Emergency Ambulance Vehicles (Target 95%).
111 Patients Called back within 1 hours (P1)	(Welsh Government performance target) which prescribes that 111 has up to 1 hour (longer for lower priory callers) for a 111 Clinician to call the patient to discuss their medical issue. These callers will already have been screened by Call Handlers and received an outcome which needs a conversation with a 111 Clinician. WAST operates a queue and call back method for all Clinical Calls.	Sickness Absence (all staff)	Staff sickness volumes as a percentage for all staff employed within the Welsh Ambulance Services NHS Trust.
999 Call Answer Times 95th Percentile	Time taken (in Minutes) to answer 999 emergency calls by call handlers. A percentile (or a centile) is a measure used in statistics indicating the value below which a given percentage of observations in a group of observations fall. For example, the 95th percentile is the value below which 95 percent of the observations may be found.	Frontline COVID-19 Vaccination Rates	Volume of frontline (patient facing and non-patient facing) who have received a second COVID-19 vaccination.
999 Red Response within 8 Minutes	Percentage of 999 incidents within the Red (immediately life-threatening) category which received an emergency response at scene within 8 minutes.	Statutory and Mandatory Training	Combined percentage of staff who are compliant with required statutory training undertaken by staff where a statutory body has dictated that an organisation must provide training based on legislation and mandatory training which relates to trade-specific training that the employer considers essential or compulsory for a specific job. (A detailed list of these can be found on slide 20).
Red 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Red (immediately life-threatening) calls (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	PADR/Medical Appraisal	Proportion of staff who have undertaken their annual Performance Appraisal & Development Review (PADR) or Medical Appraisal. This is a process of self-review supported by information gathered from an employees work to reflect on achievements and challenges and identify aspirations and learning needs. It is protected time once a year.
999 Amber 1 95th Percentile	Time taken (in minutes) for emergency response to arrive at scene for Amber 1 calls (other life-threatening emergencies – including cardiac chest pains or stroke). (NB: The 95th percentile is the value below which 95 percent of the observations may be found).	Ambulance Response FTEs in Post	Number of Emergency Medical Services, Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Return of Spontaneous Circulation (ROSC)	Percentage of patients for whom Return Of Spontaneous Circulation occurs. This refers to signs of restored circulation (more than occasional gasp, occasional fleeting pulse or arterial waveform) evidenced by breathing, a palpable pulse or a measurable blood pressure.	Ambulance Care, Integrated Care, Resourcing & EMS Coordination FTEs in Post	Number of Ambulance Care, Integrated Care, Resourcing & EMS Coordination Full Time Equivalent (FTE) staff working for the Welsh Ambulance Services NHS Trust.
Stroke Patients with Appropriate Care	Proportion of suspected stroke patients who are documented as receiving an appropriate stroke care bundle (a bundle is a group of between three and five specific interventions or processes of care that have a greater effect on patient outcomes if done together in a time-limited way, rather than separately).	Financial Balance – Annual Expenditure YTD as % of budget Expenditure	Annual expenditure (Year to Date) as a proportion of budget expenditure.
Acute Coronary Syndrome Patients with Appropriate Care	Proportion of STEMI patients who receive appropriate care. ST segment elevation myocardial infarction - occurs when a coronary artery is totally occluded by a blood clot.	Post Production Lost Hours	Number of hours lost due to ambulance vehicles being unavailable due to a variety of reasons (A detailed list of these is show in the graph on slide 22).
Renal Journeys arriving within 30 minutes of their appointment (NEPTS)	Proportion of renal journeys which arrive at hospital appointments within 30 minutes (+/-) of their appointment time.	111 Consult and Close	Consult and Close refers to the response to 999 callers where an alternative to a scene response has been provided. A cohort of 999 calls are passed to 111 where they are low acuity and the Clinicians in 111 may be able to help the caller with self-care, referral, etc. This is similar to the work of the Clinical Support Desk but for a lower acuity of caller. Where the outcome from the 111 clinical consultation ends in a Consult and Close outcome (self-care, referral, alternative transport) this is captured and forms part of the Trust’s Consult and Close reporting. Over 50% of calls passed to 111 in this way are successfully closed without an ambulance response.
Discharge & Transfer journeys collected less than 60 minutes after booked ready time (NEPTS)	Proportion of journeys being discharged from and/or transferred between hospitals which were collected within 60 minutes of the hospital booked ready time.	999 / 111 Hear and Treat	Proportion of 999/111 calls which are successfully completed (closed) without dispatching an ambulance vehicle response. This may include advice, self-care or referral to other urgent care services.
National reportable Incidents (NRI)	Volume of patient safety incidents reported in the month which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff or members of the public, during NHS funded healthcare.	% Incidents Conveyed to Major EDs	Proportion of patients transported to a hospital Emergency Department following initial assessment at scene by a Welsh Ambulance Services NHS Trust Clinician, as a proportion of total verified incidents. (NB: An ED provides a wide range of acute in-patient and out-patient specialist services together with the necessary support systems, which allow emergency admissions, and which usually has an Accident and Emergency Department).
Concerns Response within 30 Days	Proportion of concerns responded to by the complaints team within 30 working days of receiving the concern.	Number of Handover Lost hours	Number of hours lost due to turnaround times at EDs taking more than 15 minutes. Transferring the care of a patient from an ambulance to an ED is expected to take no longer than 15 minutes, with a further 15 minutes for ambulance crews to make their vehicle ready for the next call.
EMS Abstraction Rate	The percentage of Emergency Medical Services (EMS) staff unavailable for rostered duties due to reasons, such as: annual leave, sickness, alternative duties, training, other and COVID-19.		



Term	Definition	Term	Definition	Term	Definition	Term	Definition	Term	Definition
AB / ABHB	Aneurin Bevan / Aneurin Bevan Health Board	CTM / CTMHB	Cwm Taf Morgannwg Health Board	HD / HDHB	Hywel Dda / Hywel Dda Health Board	NHS	National Health Service	ROSC	Return Of Spontaneous Circulation
AOM	Area Operations Manager	C&V / C&VHB	Cardiff & Vale / Cardiff & Vale Health Board	HIW	Health Inspectorate Wales	NHSDW	National Health Service Direct Wales	RRV	Rapid Response Vehicle
APP	Advanced Paramedic Practitioner	D&T	Discharge & Transfer	HI	Health Informatics	NPUC	National Programme for Unscheduled Care	SB / SBUHB	Swansea Bay / Swansea Bay Health Board
AQI	Ambulance Quality Indicator	DU	Delivery Unit	H&W	Health & Wellbeing	NQPs	Newly Qualified Paramedic	SCIF	Serious Concerns Incident Forum
BCU / BCUHB	Betsi Cadwaladr / Betsi Cadwaladr university Health Board	EASC	Emergency Ambulance Service Committee	HR	Human resources	NRI	Nationally Reportable Incident	SPT	Senior Pandemic Team
CASC	Chief Ambulance Services Commissioner	EAP	Employee Assistance Provider	HSE	Heath and Safety Executive	OBC	Outline Business Case	STEMI	ST segment Evaluation Myocardial Infarction
CC	Consultant Connect	ED	Emergency Department	IG	Information Governance	OD	Organisational Development	TPT	Tactical Pandemic Team
CCC	Clinical Contact Centre	EMD		IMTP	Integrated Medium Term Plan	ODU	Operational Delivery Unit	UCA	Unscheduled Care Assistant
CCP	Complex Case Panel	EMS	Emergency Medical services	IPR	Integrated Performance Report	OH	Occupational Health	UCS	Unscheduled Care System
CEO	Chief Executive Officer	EMT	Executive Management Team	KPI	Key Performance Indicator	P / PHB	Powys / Powys Health Board	UFH	Uniformed First Responder
CFR	Community First Responder	ePCR	Electronic Patient Care Record	LTS	Long Term Strategy	PCR / PCRs	Patient Care Record(s)	UHP	Unit Hours Production
CI	Clinical Indicator	EPT	Executive Pandemic Team	MACA	Military Aid to the Civil Authority	JRCALC	Joint Royal Colleges Ambulances Liaison Committee	VPH	Vantage Point House (Cwmbran)
COOs	Chief Operating Officers	FTE	Full Time Equivalent	MIU	Minor Injury Unit	PECI	Patient Engagement & community Involvement	WAST	Welsh Ambulance Services NHS Trust
COPD	Chronic Obstructive Pulmonary Disease	GPOOH	General Practitioner Out of Hours	MPDS	Medical Priority Dispatch System	POD	Patient Offload department	WG	Welsh Government
COVID-19	Corona Virus Disease (2019)	GTN	Glyceryl Trinitrate	NCCU	National Collaborative Commissioning Unit	PPLH	Post Production Lost Hours	WIIN	WAST Improvement & Innovation Network
CSD	Clinical Service Desk	HB	Health Board	NEPTS	Non-Emergency Patient Transport Services	PSPP	Public Sector Purchase Programme		
CSP	Clinical Safety Plan	HCP	Health Care Professional	NEWS	National Early Warning Score	QPSE	Quality, Patient Safety & Experience		





GIG
CYMRU
NHS
WALES
Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	9
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	3

Integrated Medium Term Plan (IMTP) 2022-2025 Quarter 1 Progress Report

MEETING	Finance and Performance Committee
DATE	18 July 2022
EXECUTIVE	Rachel Marsh- Director of Strategy, Planning and Performance
AUTHOR	Alexander Crawford - Assistant Director of Strategy and Planning
CONTACT	Alexander.Crawford2@wales.nhs.uk

EXECUTIVE SUMMARY

The purpose of this paper is to update the Committee on the progress and delivery of actions in the IMTP 2022-23 to the end of quarter 1.

RECOMMENDED:

That the Committee:

1. Notes the IMTP Delivery Assurance Report attached (appendix 1), detailed extract from the IMTP delivery tracker (Appendix 2) and headlines highlighted in this executive summary;
2. Advises of any further information required to assure the Board around IMTP delivery.

KEY ISSUES/IMPLICATIONS

Appendix 1 is an assurance report which provides the following information about transformation and enabling programme activity which has commenced in quarter one and any risks going into future quarters:

- Programme Governance;
- IMTP Delivery;
- Achievements;
- Escalation of barriers and challenges to Strategic Transformation Board (STB);
- Key risks to delivery in line with strategic risks that will be raised and monitored through the Corporate Risk Register;
- Remedial actions against any deviation from IMTP delivery timescales.

An IMTP delivery tracker has been established by mapping back all 2022-23 actions into the agreed transformation and enabling programmes established within the IMTP delivery structure.

- **Emergency Medical Services (EMS) Operational Transformation** – delivers key projects to improve performance and transform operational service delivery in EMS. It also addresses commissioning intentions under the Emergency Ambulance Services Committee (EASC) EMS Commissioning Framework;
- **Ambulance Care** – incorporates the implementation of the Non-Emergency Patient Transport Services (NEPTS) D&C Review, ongoing NEPTS transformation projects and a key strategic ambition around developing a Transfer and Discharge model for Wales, again in line with commissioning intentions;
- **Gateway to Care** – brings together transformative projects around 111 and the CCC clinical review, including the ambitions for an Integrated Clinical Hub, including elements of 111 digital programme;
- **Clinical Transformation** – has been established to drive forward both the Clinical Strategy and our ambitions for the clinical transformation of EMS services, care closer to home and mental health.

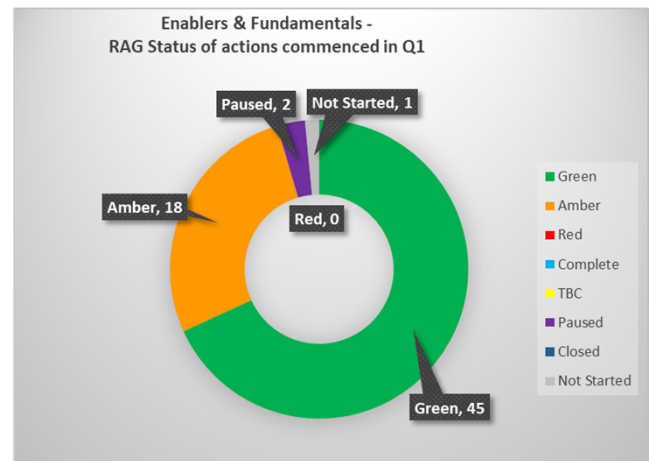
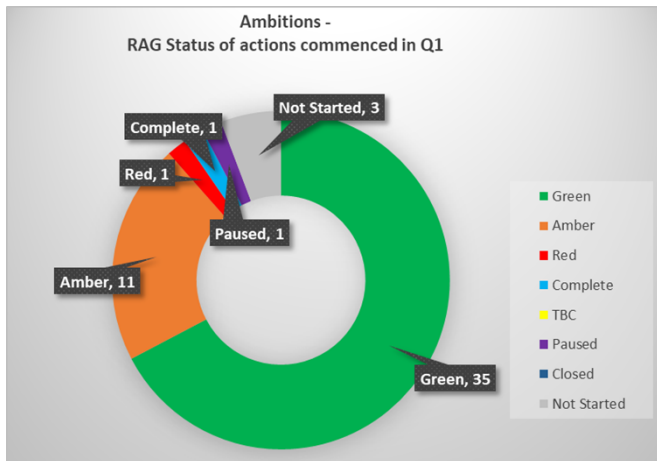
“Enablers & Fundamentals” relate to the deliverables associated with:

- **Enabling workstreams** – Our People (including the comprehensive programme of work to improve our sickness absence rates), Innovation and Technology, estates, fleet and our wider strategic partnerships.
- **Fundamentals** – the key programmes and pieces of work required to ensure that WAST is a quality driven, clinically led and value focussed organisation, including the programmes of work to transform health and safety by establishing a culture of working safely and a value based approach to service delivery, transformation and evaluation.

This year in recognition of the challenges facing both WAST and the wider NHS, STB has established three further important workstreams/programmes:

- **Financial sustainability** – established with 4 workstreams (Best Practice, Efficiency, Income Generation and Benchmarking & Value) to address the current financial challenges to enable the Trust not only to meet its statutory requirement for breakeven but also to establish the financial space to deliver further strategic development and transformation;

- **Transformation Steering and Assurance Group** – a senior forum with oversight of the wider programme of work to deliver on our “Inverting the Triangles” ambitions, focussing strongly on partnerships and engagement required to bring this ambition to reality;
- **Risk Improvement Programme** – a comprehensive programme to enhance and develop our risk management and assurance processes to ensure that risk drives organisational transformation and improvement at a strategic level.



It should be noted that only one action was due for full completion by the end of Q1:

- Implementation of the Once for Wales Service User Experience System

This action is currently Amber due to external factors with a new deadline being set, potentially into Q3.

One (1) action is rated Red (Urgent Attention Required):

- Implement the new 111 system; SALUS

The supplier continues to develop the SALUS operating software and provide clear documentation to support User Acceptance Testing. Capita has provided a draft recovery plan with milestones that reflect dialogue with WAST as the Contracting Authority. Proposed Go-Live would be May/June 2023. Commercial dialogue is in process with the intention to conclude “Change and Issue” governance by June/early July 2022.

Amber rated actions are those actions that are in progress but off track from original milestones or timelines and require some attention to bring them back on track these include:

- Prepare and agree PID for **Roster review pan-Wales (NEPTS ambulance staff)**
- Support the roll out of a **111 Press 2 Mental Health** Service through continued engagement with Health Boards
- Increasing the proportion of 999 callers who have a clinical assessment and increase **consult and close rates** for physical and mental health patients (PTAS element delayed)
- **Additional 50 APPs** to commence training (subject to EMS Transition Plan and/or Value Based Healthcare Funding agreement)
- Working in partnership with HEIW on developing a **Faculty of Emergency Mental Health** Practice
- Pilot use of **Mental Health Practitioners** in Response Cars

- Deliver **Year 2 Benefits of ePCR** Full Business Case
- **De-commissioning of DigiPen**
- Scope opportunities for and benefits of **eReferral mechanisms** for frontline patient facing clinicians
- Deliver the **Mental Health and Dementia Plan**
- Work with partners to significantly **reduce handover delays**
- Deliver the **Recruitment and Training plan** for the EMS Operational Transformation programme in the context of the transition plan
- Find opportunities to create **operational efficiencies**
- Work on our approach to **succession planning**
- Develop a **strategic workforce plan**
- Develop **change capacity and expertise** within the WOD team and across the Trust
- Embed and demonstrate the **refreshed partnership working arrangements** and behaviours with Trade Union partners and managers
- A refreshed **Leadership and Management Development Plan**
- Deliver the **new Control Room Solution** as part of ESMCP
- **Robotic Process Automation**
- **Pilot Microsoft Viva** as part of the national centre of excellence
- Develop a **forecasting and modelling framework**
- Development of business case for **Llanelli solution** (AWC)
- Development of business case for **Newport solution** (AWC)
- Development of business case for **Llandrindod Wells** (AWC)
- Secure additional **resources for further implementation of Transition Plan** arrangements
- Access further funding to support **decarbonisation** of the estate and our travel which will enable us to implement a Sustainable Travel Plan
- Develop **work packages arising from the condition surveys**
- Development of an **Infrastructure and Sustainability Strategic Outline Process** and recruitment to support this.
- Implementation of the **Once for Wales Service User Experience System**
- Review and redraft the **Public Health Plan**
- Implement the new **Once for Wales Datix Risk Module**

For these amber rated actions, a proportion are delayed due to external factors and/or funding/approval decisions. All actions have remedial plans in place at this stage.

Board and subcommittees may receive specific updates on projects or programmes listed above.

Risks and benefits

Risks to delivery are being developed as part of the risk improvement process and escalated to the corporate risk register where they are identified as strategic risks.

The focus for development of the transformation structures in 2021/22 was product delivery and establishing reporting mechanisms to track delivery via the transformation programme boards. In 2022/23, working with the Performance Team to ensure synergy with the IPR process and in line with the Quality and Performance Management Framework, the focus within the programmes will now include benefits realisation and value to establish the impact that transformation is having for our people, patients, quality and the system.

REPORT APPROVAL ROUTE

Strategic Transformation Board 27 June 2022

REPORT APPENDICES

1. IMTP Delivery Assurance Report – Q1
2. Deliverables tracker detail (2x documents)

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	✓	Financial Implications	✓
Environmental/Sustainability	✓	Legal Implications	N/A
Estate	✓	Patient Safety/Safeguarding	N/A
Ethical Matters	N/A	Risks (Inc. Reputational)	✓
Health Improvement	✓	Socio Economic Duty	N/A
Health and Safety	✓	TU Partner Consultation	✓

IMTP Delivery Programmes – Assurance Report

Quarter 1

Ambitions - Programmes

EMS Operational Transformation

Overall RAG - Amber

Key Achievements

- Relief gap closed to the extent that funding would allow (R&T targets were ambitious).
- CSD 10.2% hear & treat benchmark exceeded in 2021/22 with 36 FTE Paramedic uplift and 5 MHP uplift complete, with revised target of 15% for second half of 2022/23.
- Good progress on interim estate plan.
- Further options for recruitment made available via Transition Plan and Transition Plan reboot.

Summary

Recruitment & Training

Recent SBARs to EMT detailed new relief gap of -148 FTEs based on CHARU FTE uplift (95 FTEs), HD no EA reduction adjustment and decision to hold open sufficient vacancies in Response to fund the 36 Paramedic uplift into CSD. Further work currently being undertaken on due diligence around figures, in particular, working from pan-Wales control totals to health board, locality and station totals.

Roster Review

Recent paper to EMT to confirm decision to proceed to go live Sep-22 to Nov-22. Some o/s R&Rs and petition from Monmouth.

Estate Contingency

Estate interim plan on target, with exception of Llanelli station where work around required.

The CCC Reconfiguration Project

Stopped due to various pandemic waves. PID expected in 3 weeks' time which details ambition within existing resource restraint.

Risk & Issues

Risk for Noting

- (1) Further funding (£3m) has risk about ability to recruit, train and place into estate.
- (2) There is some workforce unease around the roster review project.
- (3) There is high public/political interest, in particularly, in Monmouthshire (3 RRVs being removed no CHARUs) with active management by the CEO, Director of Partnerships and Engagement and AD Commissioning & Performance.

Issue for Noting

- (1) C1 Licence issue.
- (2) Impact of abstractions and handover on ability to deliver benefits.

Ask from STB

None

Ambulance Care Transformation Programme

Overall RAG - Green

Key Achievements

- Demand and Capacity: The NetCall call back trial is complete, and staff are preparing for go live.
- NEPTS Operational Improvement: The new Resource Downtime report has been produced, action cards have been rolled out to Operational and Control staff with a supporting briefing document. A familiarisation session has taken place with OMs and SMs to respond to queries and manage expectations.
- Transfer and Discharge: An SBAR has been signed off at STB regarding the key principles for developing a service for time critical transfers. Project documentation has been reviewed by the project team and the scope and project objectives are being refined.
- Plurality Model: The tender process for 2+1+1 contracts has started, through 365.
- NEPTS Update of Existing CAD: The data purge on the live account was completed on 4th May 2022 and the live account was upgraded to the latest version on 24th May 2022.

Summary

NEPTS Demand & Capacity Review

D&C Project:

Two of the three surgeries have taken place with the Service Managers (previously known as General Managers) regarding reviewing the demand keys. The final meeting is due to take place in early July, due to planned annual leave.

Oncology:

The first draft of the PID has been reviewed and suggested changes to refine this have been discussed.

Outbound Ready Times (PDSA):

PDSAs on ready times completed with varied results from tests of change.

NET Centre, Planning and Day Control:

The NetCall call back trial is complete. Staff are being introduced to the new process before full go live.

A project plan is being developed for the NET Centre roster review. This includes a review of the demand data.

A previously advised, funding has not been agreed for 2022/23 for 12.2 FTEs within planning and day control. This IMTP deliverable has therefore been categorised as "stopped" for this financial year.

NEPTS Plurality Model

The tender process for 2+1+1 year contracts has started, through 365. The tender process for contracts which will be less than 12 months will follow.

Procurement of DPS has commenced through G-Cloud as agreed by SLT

Transport Solution

The future of eligibility has been discussed with the Chief Ambulance Services Commissioner's office and the project is currently awaiting further guidance on a way forward.

Transfer and Discharge

NHS England Quality Surveillance Team have responded to WASTs self-assessment with a letter advising there no immediate risks identified and no serious concerns identified, although there are likely to be recommendations around the major trauma desk operating 24/7. The project is currently awaiting the final report on this.

The Transfer and Discharge project team is established to prepare for the commencement of the project from Q2. The NCCU are represented in this meeting, and they have subsequently been briefed on progress within WAST on developing a PID and project documentation.

Project documentation has been updated but not finalised as some of the information around scope needs to be agreed following the meeting with NCCU, as well as outcomes and benefits to ensure alignment with commissioners' intent.

An SBAR has been signed off at STB regarding the key principles for developing a service for time critical transfers.

There has been a growing number of concerns, NRIs and an inquest in ongoing in North Wales relating to delayed transfers. WAST is working with BCU Health Board and has offered to develop a transfer model and service with health board colleagues and the NCCU ahead of the development of the commissioning framework and all Wales model.

NEPTS CAD

The data purge on the live account was completed on 4th May 2022 and the live account was upgraded to the latest version on 24th May 2022.

Work is underway to identify users of mobile devices in order to arrange upgrade of licenses for upgraded Cleric.

Follow up with training 'champions' undertaken.

NEPTS Operational Improvement

Oncology: The aim of this project is to standardise the booking process for Oncology. A PDSA was due to start with Velindre Cancer Centre on the 4th April and in the last highlight report it was explained that the project was awaiting a Lead from Velindre to oversee this; this remains the current position.

Cancellations: The aim of this project is to maximise the usage of the discharge lounge which is the most efficient way to avoid cancellations.

Due to personnel changes within BCUHB, the trial for this has been slightly delayed. However, the trial was initially going to take place in one ward but it has been agreed that a PDSA will be undertaken and this will cover 3 wards, therefore allowing for more data to analyse the outcome of the PDSA. The PDSA started on 9th May.

National standardised guidance and risk assessments: The aim of this project is to ensure risk assessments and SOPs are completed to standardised NEPTS procedures. These include transporting patients via stretcher, by a wheelchair and with the use of a tail lift.

A gap analysis has been undertaken to identify areas which do not currently have a SOP or risk assessment. The project team are meeting with TU colleagues w/c 25th April to discuss the results of the gap analysis before beginning work on the missing risk assessments.

Resource Downtime (previously referred to as Post Production Lost Hours): The aim of this project is to move away from the current 'Resource Downtime' report and create a new report, which is specific to post production lost hours with a view to mirror the report used by EMS.

As previously reported a new report has been created on Qlik which contains an agreed shortened list of downtime reasons. Within the last reporting period, action cards have been rolled out to Operational and Control staff with a supporting briefing document. A familiarisation session has taken place with OMs and SMs to respond to queries and manage expectations.

Risk & Issues

Risk for Noting

None

Issues for Noting

None

Ask from STB

None

Gateway to Care

Overall RAG - GREEN

Key Achievements

- SALUS: Capita have circulated a draft recovery plan – discussions continuing to agree revised programme milestones
- Successful mitigation of 111 Call Handler over-establishment
- Allocation of £250,000 funding to progress the 111 public promotion campaign confirmed
- ECNS was successfully implemented on 17th May 2022.
- Process mapping workshop undertaken to map current CSD process and review current remote clinical leadership processes
- RCDM: Confirmation of funding received for 18 places for next years' courses planned for Sept 2022, Jan 2023.
- 111.Wales website: Progress continues to develop the website infrastructure including a new homepage and re-engineering the primary sections of the site to have a single style (ie NHS front-end standard). Preliminary approval given by 6 Goals Implementation Board for £238,000 to run the interim team until Mar 23.
- Work has commenced with the Trust People Services department on the creation of a long-term workforce plan for 111.

Summary

The G2C programme continues to deliver good progress. The 111 service is now a national service following the successful launch in C&VUHB. 111 performance continues to show positive trends. Following the implementation of the new CSD roster, a lessons learned meeting took place on the 29th March followed by a feedback session on the 26th April 2022.

SALUS continues to be delayed by the external provider and is the only project with a RAG status RED.

ECNS was implemented on 17th May 2022.

Formal confirmation from Welsh Government that 111 First is not being funded recurrently has been received. This will impact delivery of the service and work continues to manage the financial impact on the Trusts 2022/23 budget.

Approx. 40 colleagues completed the WAST internal Remote Clinical Decision Making module between Sept 2021-May 2022. Meeting arranged for the 27th June to finalise the numbers.

Core 111 Service

Successful implementation and embedding of the core 111 service in C&V following launch in March. Work is ongoing with the programme team to finalise the funded baseline workforce requirements for 2022/23 for Call Handling and Clinical Advisors.

111 First

111 First service commenced in C&VUHB on the 16th March 2022 aligned to the roll out of the core 111 service. Welsh Government have confirmed this project will not receive recurrent funding for 2022/23 and beyond. Options are being explored to roll out the pathway for current demand in Hywel Dda and Cwm Taf Health Boards (where there is no additional impact on 111 activity or resources required to deliver the service)

CCC Clinical Review

- **ECNS:** ECNS was implemented on 17th May 2022. Training is to be completed for all CSD Clinicians by the end of July, at which point MTS will be switched off. The project is developing plans to increase functionality (video consultation etc) as soon as possible with a provisional date to be confirmed.

- **CSD Roster Review:** A lessons learned meeting took place on the 29th March followed by a feedback session on the 26th April 2022.
- **Increasing the Clinical Support Desk (CSD) by 36 FTE Paramedics:** Pending workforce plan. This project, and the recruitment of new starters and the management of leaves is starting to become 'Business As Usual'. A meeting is scheduled for 9th June to hand this over from the Project Manager to CSD and as part of this the workforce plan will be created.
- **Physician Triage Assessment and Streaming (PTAS):** Currently, Hywel Dda and Betsi remain the only Health Boards who are live with PTaS. Weekly updates continue to be provided to EASC and NCCU.
- **111 Digital Programme**
 - Further delays to SALUS roll out puts more pressure on the CAS system and possible system issues due to the pausing of key software updates / development that may be required for continued use of the system.
 - Capita provided draft Recovery Plan with milestones that reflect dialogue with Authority. Proposed Go-Live would be May/June 2023. Commercial dialogue in process with the intention to conclude Change and Issue governance by June/early July 2022.
 - New homepage launched. Surfaced content associated with the June Bank holiday, to ensure patients were aware of primary care restrictions. Tested new technical endpoints for global search on 111.Wales, due to server changes in DHCW.
- **RCDM:** Confirmation of funding received for 18 places for next years' courses planned for Sept 2022, Jan 2023.

Key Risk & Issues

Risk for Noting:

- Capita Readiness: Continued delays regarding the readiness and quality of the SALUS system to enable User Acceptance Testing.
- Impact on lack of 111 First funding is currently being scoped in respect to the 111 Workforce plan.

Ask from STB

None

Clinical Transformation Programme

Overall RAG - Green

Key Achievements

Care Closer to Home:

- EMS Transition Business Case and Value Based Health Care Bid submitted to support the funding to expand the APP Workforce. Awaiting decision.
- National Criteria for SDEC published by Welsh Government. SDEC implemented in Withybush Hospital, HDUHB (09/05/22) with local variance to the National Criteria.
- WAST Representation on the National Procurement Panel to choose provider for the next 3 years (currently Consultant Connect) - scoring panel 30/05/22
- Agreement to pilot a Semi-Automated Solution for eReferral with the long term aim of a Fully Automated Solution (subject to capital funding)

Mental Health & Dementia:

- HDUHB went live on 20/06/22. Advised that an MOU had been agreed 17/06/22 and IVR change on 20/06/22
- Proposal submitted to Welsh Government on HEIW recommendation for a Faculty of Emergency Mental Health Practice
- 5 WTE MHPs currently going through their induction - two now fully signed off and the remaining three will be signed off next 2 weeks. These will start on the full-time rota in Jun-22

TerraPACE Project Phase 1 Activities Continued

- Deployment to English Hospitals - March TerraPACE Project Board agreed 10 sites from a report of 57 English hospitals to implement the portal in. Revised plan to complete implementation by end of June.
- DHCW WGPR Patient Summary Interface - Plan developed with DCHW and Terrafix to deliver WGPR Interface and NIIAS Auditing - revised delivery date to achieve governance required by DHCW is end of August 2022.

TerraPACE Project Phase 2 Activities

- Clinical Information and Reporting - Increased scope from data warehouse development to include replacing the current Digital Pen PCR retrievals service, mortality reviews and CTL performance system.
- TerraPACE Product Development Post Live - Clinical Reference Group established in April 2022. Mechanism for approvals and testing being formulated.
- Mass Casualty Information System (MCIS) Software - Terrafix development of the product for WMAS on track.

Falls & Frailty

- BCUHB have 2 x Paramedic/Occ Therapist Teams available: East provide a 4 days/week service and are looking to expand to 7 days/week. Funding has been secured for 5 years. Central: same model which started in May-22 for a 4 month pilot.
- Completed filming on OPs and F&F Improvement video available to internal and external stakeholders

Older Persons

- Value Based Health Care bid, submitted by Powys, for additional resources to support Falls Prevention and use of the iStumble Tool.

Clinical Intelligence Assurance Group

- 50% of DigiPens have been returned and processed. Of the 50% returned DigiPens, 2,300 PCRs have been extracted
- DigiPen licence contract extension agreed at EMT until 30/9/22 (6 months)

- Approval from CQGG to cease internal reporting on DigiPen CI Data from December 2021 until April 2022.
- Raw data for #NOF & Stroke published as ASIs by EASC (reduced compliance and #NOF ePCR CI data audit approved at CIAG)

Summary

CARE CLOSER TO HOME

Expansion of APP workforce

Value Based Health Care Bid submitted outlining the requirement of 30 or up to 50 APPs. Outcome due end Jun-22. Confirmation of funding received from HEIW of £150k, including 10 Independent Prescribers. Modelling data provided by ORH on the future APP workforce.

Optimising Conveyance

Meeting held in May-22 for initial brainstorming for the Optimising Conveyance Strategy. Continue discussions with SBUHB to implement the COPD Pathway. Agreement to open a designated Pathways WIIN Platform for staff to put forward their ideas. Care Closer to Home WIIN Sub-Group to be established, membership to include the Consultant Paramedics for Urgent & Emergency Care (chair) and Health Board Clinical Leads. UPCC National Criteria and Pathway remains on the agenda for the Clinical Reference Group. SDEC Implemented in Withybush Hospital 09/05/22 (not national criteria - local variance in place). Approval of SBAR to CC2HG May-22 on how to capture the local SDEC variances (benchmarking database).

Telephone Advice & Guidance (currently Consultant Connect)

Procurement Process is restarted.

MENTAL HEALTH & DEMENTIA

111 Press 2

Hywel Dda UHB went live on the 20/06/22. Advised of an agreed MOU on 17/06/22 and changes made to the Cloud IVR on 20/06/22 in the morning to allow services in HDUHB to go live.

Further discussions are being had around the wording of the IVR. The Mental Health Programme Board agreed that the governance and approval of the wording would be with WAST as we are the provider of the service.

Faculty of Emergency Mental Health

Proposals have been submitted to Welsh Government on the HEIW recommendation for the Faculty of Emergency Mental Health Practice. Decision pending and outcome due end of June-22. Initial discussions have been held with BCUHB on piloting Mental Health Response Vehicles, further decision needed around funding.

Mental Health Practitioners in the CSD

5 out of 6 FTEs have gone through induction training and will start on the fill rota in June-22. Remaining 1 FTE has been appointed and planned induction.

OLDER PERSONS AND FALLS & FRAILTY

Older Persons

Ongoing Powys Care Home PDSA to identify the use and learning of the iStumble Tool. Ongoing discussions with the Commissioner to evaluate the iSTUMBLE Tool and use of Lifting Cushion. Value Based Health Care bid, submitted by Powys, for additional resources to support Falls Prevention and use of the iStumble Tool.

Falls & Frailty - Clinician / Therapist Response Teams

There are two Paramedic/Occupational Health Therapist Teams available in BCUHB; East providing a 4 day/week services with the intention to expand to a 7 day/week. Funding for this service has been secured for 5 years. Central are piloting the same model for 4 month. Further discussions are being held to have a third Team in BCUHB. ABUHB are looking for a longer-term funding solution to support the model for 5 years. Full Service Evaluation to be developed to inform next steps to spread & scale. Early discussions with CVUHB to fund a Response Team. National Falls & Frailty Response Model SOP in development.

Risk & Issues

Risk for Escalating:

- Failure to secure funding from Welsh Government to increase APP Workforce by 50 FTEs

Ask from STB

None

Strategic Development

Overall RAG - Green

Key Achievements

Preparation for Change:

- Transformation Assurance Steering Group established; initial meeting held 13/06/22. This group will provide strategic leadership and oversight of the EMS Transformation Programme.
- Draft Terms of Reference developed identifying governance and reporting mechanisms, and membership.
- Arrangements considered for the establishment of a Transformation Delivery Network to execute and deliver the EMS Transformation Plan
- Approval of funding, by EMT 18/05/22, to recruit additional post. Concerns regarding the delays in the Job Evaluation Process, and, therefore the recruitment of the dedicated posts, that will impact on the delivery of the EMS Transformation Programme

Stakeholder Engagement:

- Two workshops held (Dec-21 and Feb-22) to begin initial conversations around what "inverting the triangle" means for the organisations and identify what needs to be considered to support us with the transformational journey.
- TUP Engagement Workshop (May-22)
- Initial discussions with the CHC regarding the requirement of a Formal Public Consultation. Further understanding is needed to determine the scale of this workstream.

Progress of service developments, currently being delivered through other Programme Boards:

- Expansion of APP Provision
- Expansion of CSD Provision
- Rollout of ECNS:
- APP Navigator Pilot:

Summary

A Transformation Assurance Steering Group has established to provide strategic leadership and oversight of the EMS Transformation Programme. First meeting held on 13/06/22, with discussions around its draft Terms of Reference which identified the groups governance and reporting mechanisms, and membership. Further consideration is needed on key workstreams of the group, to date engagement has been identified as a key workstream reporting into STB and Board.

Agreement to establish a Transformation Delivery Network to execute and deliver the EMS Transformation Plan. This will be supported by the additional posts that were approved by EMT 18/05/22. There is a concerns regarding the delays in the Job Evaluation Process, and, therefore the recruitment of the dedicated posts, that will impact on the delivery of the EMS Transformation Programme.

Further consideration is needed to the key workstreams of this programme. To date, Engagement has been identified relating to Formal Public Consultation. Further discussions are needed to determine the scale of this workstream and conversations with Legal & Risk have commence to gain clarity on the Consultation Guidance.

Risk & Issues

- Failure to recruit into the additional post in a timely manner due to delays caused within the Job Evaluation Process

Ask from STB

None

Financial Sustainability

Four Financial Sustainability Workstreams have been established and the first meetings held in the week commencing 20th June 2022.

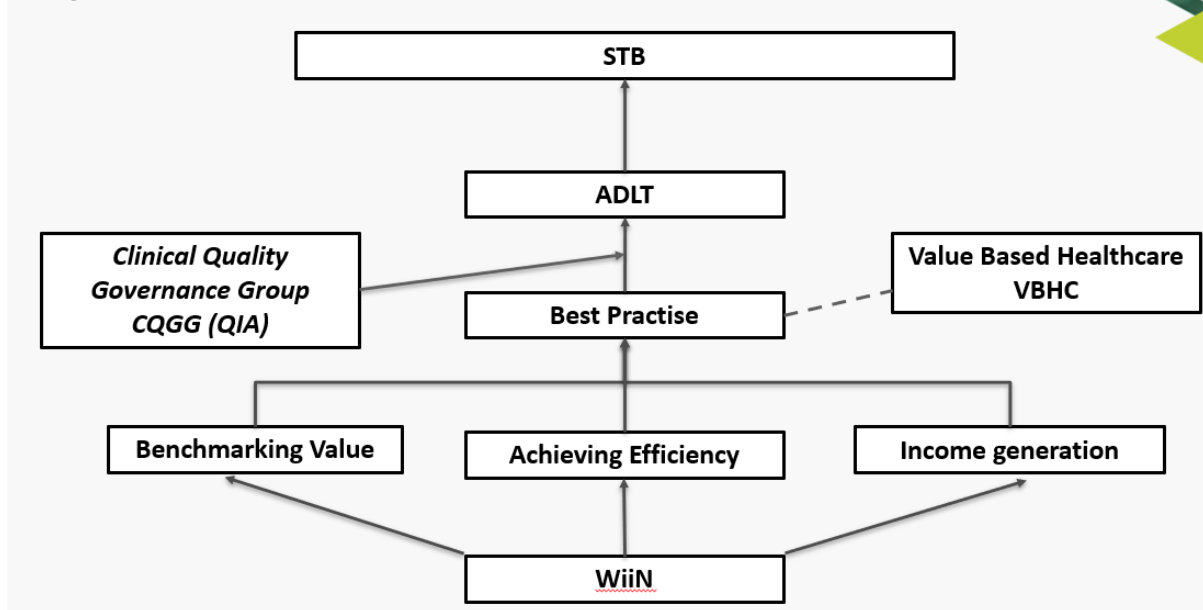
<p>Benchmarking Value</p> <ul style="list-style-type: none"> ➤ Review Carter report ➤ Review AW Blue light report ➤ Benchmarking ➤ Review of benefits realisation of recent investments 	<p>Achieving Efficiency</p> <ul style="list-style-type: none"> ➤ Admin Review ➤ Other workforce / skill mix opportunities ➤ Fleet maintenance ➤ Estates ➤ Outsourcing opportunities 	<p>Income generation</p> <ul style="list-style-type: none"> ➤ Apprenticeships ➤ Provision of services ➤ Alternative funding sources ➤ Commercial opportunities 	<p>Best Practise</p> <ul style="list-style-type: none"> ➤ All other opportunities from initial and future reviews ➤ Existing ADLT savings group ➤ Savings tracking
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The Best Practise FSW (via the Deputy Director of Finance & Corporate Services) shall report to the Assistant Director Leadership Team (ADLT) on a quarterly basis with STB also supporting the ongoing development of its forward work programme to consider planning and delivery issues.

At its discretion ADLT, STB, EMT or the Finance & Performance Committee may commission further specific work from the FSW as well as prioritisation of certain subjects.

The overall Governance structure for the savings program is provided in figure 2 below.

Proposed Governance



It is proposed for The Clinical Quality Governance Group (CQGG) to provide Quality Impact Assessments (QIA) oversight of all savings the FSW decides to pursue, so that all savings and efficiencies that are planned to be delivered maintain or enhance quality of service to WAST patients.

The WAST Improvement & Innovation Network Sub-Group (WIIN) via its own work on efficiency and service improvement may feed in with a degree of its own identified cash releasing working schemes into the FSWs.

WAST has also set up the Value Based Health Care (VBHC) group which may provide some overlap in output with the FSWs and it will be beneficial to keep the VBHC group abreast of the work of the FSWs and vice versa.

Enablers and Fundamental

Our People

Overall RAG - GREEN

Key Achievements

- Draft Recruitment and Training Plan developed, aligned with the Transition Plan; delivery of this is currently on hold pending receipt of funding.
- Design and delivery of a bespoke RPL (Recognition of Prior Learning) driver education programme for BASICS Doctors and EMRTS, wc. 20th June 2022 for 4 weeks.
- Establishment of Task and Finish Group associated with the All Wales Speaking Up Safely Guidance.
- Completion of Just Culture training for several WAST colleagues and TUPs.
- Timeline for development of strategic workforce plan shared with Integrated Planning Group.
- Guidance regarding return to office compiled and circulated.
- Facilitated workshop for Board members (22.06.2022) to support and prepare Board members to embed and role model new WAST behaviours
- Succession Plan Diagnostic tool completed to inform action plan

Summary

Design and delivery of a bespoke RPL (Recognition of Prior Learning) driver education programme for BASICS Doctors and EMRTS, wc. 20th June 2022 for 4 weeks, enabling these colleagues to gain a Level 3 Certificate in Emergency Response Ambulance Driving, in preparation for implementation of Section 19 legislation (first UK Ambulance Service to do so, with other services now seeking our support and advice on the process).

Work associated with the 'Leading Service Change Together' agenda has been put on hold pending conclusion of ACAS meetings; first ACAS facilitated meetings now complete but due to Covid, second ACAS session has been postponed (to take place during Q2).

Good progress is being made in relation to the Managing Attendance Action Plan, with colleagues reporting good engagement across all teams and a downward trajectory in absence rates.

Work ongoing with Governance Team to develop an effective cycle of business for People and Culture Committee, plus a full review of associated Sub-Groups.

Development of the People and Culture Plan underway with Directorate engagement session held on 23.06.2022.

Risk & Issues

Risk for Noting

Some risks around our partnership relationships with TUs as well as the risk of temporary disruption due to the leadership changes in WOD senior team.

Issue for Noting

People Services and OH capacity to deal with demand generated by Managing Attendance Plan.

Delays to 'Leading Change Together' agenda (resulting from postponement of ACAS meetings as a result of Covid)

Risks for escalation

N/A

Issues for escalation
N/A
Ask from STB
None

Innovation & Technology

The majority of strategic digital delivery sits within the key transformation programmes above.

On those that sit directly with the digital directorate to deliver the majority are on track. However, some issues have arisen which may delay the Control Room Solution project and the Robotic Process Automation Project requires some focus through ADLT to ensure delivery within the timeframes available this year.

Estate and Fleet SOP

Estate SOP continues to support the different short term contingency plans and long-term strategic ambitions; however, areas of resource constraint are highlighted, and these will impact on timely completion. Actions, risks, and issues are being managed via Estate SOP Delivery Group.

Cardiff MRD and Beacon house are now open with positive feedback.

A scoping meeting with Welsh Government has been set for Mid-July regarding the development of an OBC for Swansea MRD replacement.

The Project Board for the South-East Fleet Workshop has been re-established and work packages are commencing.

Business cases for Llanelli, Newport, Llandrindod Wells and Bangor Fleet Workshop will commence in Q2.

Work is ongoing for several projects and are on track.

Revised vehicle replacement programme confirmed with WG and on target for new plan. BJC 22/23 document submitted to WG and gained formal approval to proceed, work is ongoing.

Implementation of the Environmental and Sustainability Strategy is on track, couple of amber ratings reported as awaiting outcomes of funding bids to WG to support decarbonisation of the estates and our travel, development of work arising from condition surveys. Project Managers support is also key and planned to be available in Q2.

Working Safely Programme

The Working Safely Dynamic Delivery Group is making good systematic progress with the prioritised actions, with task and finish groups now established taking responsibility for each action.

The work programme, recognising the pressures on operational staff and necessity for the health and safety programme team to cover business as usual has been prioritised and aligned.

However, progress has now been made with securing additional members of the Programme Team and business as usual team enabling the plan to be reviewed to identify what other deliverables will now be achievable from the overarching plan.

Quality Fundamentals

A lead has been identified to support the roll out of the Quality Strategy Implementation Plan and is currently on track. The evaluation of QuEST is underway and is on track for review at the next meeting in August 2022.

The implementation of the Once for Wales Service User Experience System is in the final stages with training to be rolled out in July. The PECl team continue to work on the development of the People and Community Network and engagement work programmes including more face to face as restrictions have eased.

The Public Health Plan will be refreshed in Q2, related deliverables of working in partnership with PHW and Velindre are to be revisited.

Risk Management

The immediate priority of the transformation programme was to undertake a full review of the Trust's highest scoring risks: Risks 223, 224, 199, 316 and 160 which has been completed. New titles have been determined, and the risks clearly articulated with new summary descriptions, utilising an 'if, then, resulting in' approach. The controls and assurances have been mapped together and any gaps identified. Further actions have been identified to mitigate the risks in addition to reviewing the scores and controls rating assurances.

The same process has also been applied to the remaining Corporate Risks on the CRR. The work to finalise the mapping of assurances, controls and gaps will be completed in July 2022.

A transitional BAF was presented to the Audit Committee in June 2022 that focusses the Board on the key risks that might compromise the achievement of the Trust's strategic objectives. As the Trust's risk maturity advances this template will be used to capture the risks to the strategic objectives and will be cross-referenced to the principal corporate risks.

The Trust has recently undergone an Internal Audit review on Risk Management & Assurance which received a Reasonable Assurance rating.

The Governance Team are members of national Risk Management Groups who are currently working with RL Datix on the design phase of the new Once for Wales Datix Risk Module. This is expected to be implemented by March 2023; however, there have been delays in receiving the agreed updates to the system from RL Datix which incorporate the group's requested amendments and improvements.

The Risk Management Strategy (2018-21) will not be refreshed; however, a clear Risk Management Framework is in development which incorporates the IMTP deliverables described above, a Risk Management Policy, associated procedures, and Board and organisational risk management training.

Appendix 2A – Ambitions

Note: The tracker shows all actions, including those not yet commenced in Q1

Prog Ref.	Deliverable 2022-25	Actions in 2022-23	Start	End	Q1 Status
EMS Operational Transformation Programme SRO: HB	We will increase and balance response capacity and capability across urban and rural areas of Wales	Maintain closure of relief gap and implement transition plan, increasing by up to 294 WTE subject to funding	Q1	Q4	NS
		Continue to work with rural areas to improve red response times	Q1	Q4	G
		Take forward year 2 actions of our volunteering strategy	Q1	Q4	G
		Implement roster changes	Q1	Q3	G
	Patients who ring 999 but who don't have a life threatening or emergency need receive the appropriate level of care and access to the most appropriate pathway 24/7	Consider appropriate and achievable reductions in PPLHs	Q1	Q2	P
		Reduce roster abstractions due to sickness absence through implementation of robust action plan			
		Work with partners to significantly reduce handover delays	Q1	Q4	A
We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience	Implement a CHARU model to improve clinical outcomes, ROSC rates and response times	Q2	Q3	G	
Ambulance Care Transformation Programme SRO: MH	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand.	Prepare and agree PID for Roster review pan-Wales (NEPTS ambulance staff)	Q1	Q2	A
		Possible 12.2 FTEs for planning and day control (FUNDING NOT AGREED FOR 22/23)	Q1	Q2	C
		Re-roster of NET centre staff	Q1	Q4	G
		Reduction in T1 walkers demand – work with commissioners on eligibility criteria	Q1	Q4	G
		Review and consider use of ambulance car service	Q1	Q2	G
		Review resource downtime (previously referred to as post-production lost hours)	Q1	Q4	G
	We will develop and implement with partners an All-Wales Transfer and Discharge Service	Work in partnership on Commissioning Framework / business case for Transfer and Discharge services (including mental health)	Q2	Q4	G
		Implementation of the Vascular Network in SE Wales	Q1	Q2	G
		Respond to and introduce agreed recommendations from Peer Review of the Major Trauma Network	Q1	Q2	G
	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service	Transfer of IMTP as 'business as usual' and benefits realisation of the use the PNA and signposting document.	Q1	Q4	G
		Work with Commissioners on agreement and implementation of eligibility criteria	Q1	Q4	G
	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience	Development of quality standards approach for external providers	Q1	Q4	G
		Agreed Standard Operating Practice document for bookings	Q1	Q4	G
Work with a local hospital to maximise the usage of the discharge lounge, to reduce cancellations.		Q1	Q4	G	
	Finalise the National standardised guidance and risk assessments.	Q1	Q4	G	

Prog Ref.	Deliverable 2022-25	Actions in 2022-23	Start	End	Q1 Status
Gateway to Care Programme SRO: RM	We will work with partners to promote and expand use of 111 across Wales	Work with 111 Programme Team to support the development of a National Strategy for 111 including associated workforce strategy	Q2	Q4	G
		Evaluate core 111 service	Q2	Q3	G
		Roll out of 111 First across Wales (subject to further discussions)	Q1	Q4	G
		Support the roll out of a 111 Press 2 Mental Health Service through continued engagement with Health Boards	Q1	Q4	A
		Robust national communication campaign / messaging (subject to funding)	Q1	Q3	G
	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team	Implementation of recommendations from CCC Clinical Review	Q1	Q4	G
		Develop remote clinical support strategy	Q1	Q4	G
		Develop a clinical specialty educational and career framework for Remote Clinical Decision-making (RCDM)	Q1	Q4	G
		Increase proportion of 999 callers who have a clinical assessment and increase consult and close rates for physical and mental health patients – 15% used in modelling	Q1	Q4	A
		Implement 999 Triage system (ECNS)	Q1	Q4	G
		Develop a case for change on the integration of clinical teams across 111 & 999	Q1	Q3	G
		Identify opportunities to increase 'consult and close' rates (subject to funding)	Q1	Q4	NS
	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations	Identify pilot opportunities to test direct booking system for 111 patients to Health Board services	Q1	Q4	NS
		Implement the new 111 system; SALUS	Q1	Q4	R
	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience	Continue to implement the 111 Stabilisation & Transformation Plan designed to deliver agreed staffing levels, utilized as effectively and efficiently as possible to meet demand and reduce call answer / clinical ring back times	-	-	C
		Develop a strategic 111 workforce plan	Q2	Q4	G
	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice	Deliver an improved Directory of Services	Q1	Q4	G
		Improve 111.Wales website , and enable better digital self-service (subject to funding)	Q1	Q4	G
		Develop a clearer vision with partners for a digital 111 offer in Wales, including case for longer term / recurrent investment	-	-	
		Further enhance and develop WAST internal reporting functions for 111/111 First	Q3	Q4	G

Prog Ref.	Deliverable 2022-25	Actions in 2022-23	Start	End	Q1 Status
Clinical Transformation Programme SRO: AS	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients	Additional 50 APPs to commence training (subject to EMS Transition Plan Funding agreed)	Q1	Q4	A
		Existing APPs to commence Independent Prescribing training (subject to EMS Transition Plan Funding agreed)	Q3	Q4	G
		Agree case for longer term growth in APPs	Q3	Q4	NS
		Work in partnership with HEIW on developing a Faculty of Emergency Mental Health Practice	Q1	Q4	A
		Pilot use of Mental Health Practitioners in Response Cars	Q1	Q4	A
		Deliver and implement the Clinician/Therapist Falls & Frailty Response across Wales, seeking collaborative programmes/services through partnerships and alliances with external stakeholders	Q1	Q4	G
		Complete full TerraPACE Project (ePCR)	Q1	Q4	G
		Deliver Year 2 Benefits of ePCR Full Business Case	Q1	Q4	A
		De-commissioning of DigPen	Q1	Q4	A
		Develop Optimising Conveyance Strategy	Q1	Q4	G
	Explore use of technology to facilitate supported remote consultation via additional platform rather than solely face to face	Q2	Q4	NS	
	Enhancing our provision of analgesia across our EMS and volunteers	Q2	Q4	NS	
	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover	Work with partners to develop ED avoidance Referral Pathways	Q1	Q4	G
		Scope opportunities for and benefits of eReferral mechanisms for frontline patient facing clinicians	Q1	Q4	A
		Undertake evaluation of Mental Health Practitioners in CSD	Q1	Q4	G
		Determine key improvements and opportunities for collaboration following the introduction of the Older Persons Framework	Q1	Q4	G
		Supporting the Urgent Primary Care and Same Day Emergency Care Centres	Q1	Q4	G
		Embed preferred technical platform to access senior clinical support (subject to announcement from Welsh Government on provider 2023/22 Q4)	Q1	Q4	G
		We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience	Develop a clinical indicator plan	Q1	Q4
	Deliver the Mental Health and Dementia Plan		Q1	Q4	A
Assess and evaluate system wide improvements following the introduction of the Falls & Frailty Framework including the Falls & Frailty Response Model	Q1		Q4	G	
We will implement the Clinical Strategy to support developments across our service ambitions	Review the strategy to incorporate activity related to "inverting the triangle" and Clinical Leadership and Continue the delivery of the Clinical Strategy through the Clinical Transformation Programme Board	Q1	Q4	G	

Appendix 2B – Enablers and Fundamentals

Note: Note: The tracker shows all actions, including those not yet commenced in Q1

Prog Ref.	Deliverable 2021-24	Actions in 2022-23	Start	End	Q1 Status
Our People CG	We will take actions to increase the level of resources and support available to our people in relation to their well-being	Deliver the Recruitment and Training plan for the EMS Operational Transformation programme in the context of the transition plan	Q1	Q4	A
		Find opportunities to create operational efficiencies so the workforce can maximise productivity by working smarter, exploring creative, longer term workforce solutions to forecast needs and planned growth.	Q1	Q4	A
		Implement our absence management recovery plan and develop resources and sensitive interventions designed to ensure colleagues remain healthy and well at work.	Q1	Q4	G
		Develop our recruitment plans to enhance 'grow our own' into employment, with a focus on growing apprenticeship opportunities, access pathways, new routes of supply (overseas recruitment) and school engagement	Q1	Q4	G
		Work on our approach to succession planning for future senior leadership posts including development centres.	Q1	Q4	G
	We will effectively manage risk, governance and compliance	Appropriately respond to the legislative changes associated with Section 19 of the Road Traffic Act regarding driver education.	Q1	Q4	G
		Work with the governance team to build on the People and Culture Committee effectiveness and empower its sub-groups to effectively discharge its accountabilities.	Q1	Q2	G
		Implement the All Wales Speaking Up Safely Guidance, provide improved training for managers and ensuring appropriate systems and processes are in place for concerns to be raised and dealt with in a positive and constructive way.	Q1	Q3	G
		Improve the effectiveness and safety of our internal disciplinary, capability and resolution processes , learning from Just Culture principles and other learning.	Q1	Q2	G
	We will purposefully shape our future ways of working and equip our people to thrive in a changing environment through our refreshed People and Culture Strategy	Develop a strategic workforce plan that defines the shape and skill mix of the workforce needed to deliver our long-term ambitions including transferrable and digital skills.	Q1	Q3	A
		Identify and develop agile ways of working such as opportunities for matrix working and organisation re-design to address future business challenges and make sustainable change.	Q2	Q4	NS
		Create a shared vision for WAST as a learning organisation, ensuring systematic individual, team, organisational and Board learning to inform service and policy design, strategy development and decision making.	Q1	Q4	G
		Develop change capacity and expertise within the WOD team and across the Trust to support and enable the organisation to deliver its transformational plans.	Q1	Q4	A
		Embed and demonstrate the refreshed partnership working arrangements and behaviours with Trade Union partners and managers, regularly reviewing and reflecting and leading change together.	Q1	Q4	A
	We will take actions to foster a culture of belonging and wellbeing where our people can engage, feel supported and represented.	Launch and embed our new behaviours to make tangible change by continuing to build a diverse, inclusive and compassionate culture, promoting a sense of belonging.	Q1	Q4	G
		Develop opportunities to listen, such as pulse surveys, to temperature check how people are feeling and act on feedback by using a 'you said, we did' approach.	Q1	Q4	NS
		Continue to deliver the strategic equality objectives making a demonstrable organisational commitment to promote and roll out the Allyship programme to all colleagues and Non-Executive Directors.	Q1	Q4	G
		Continue to identify and promote access to development opportunities, CPD, experiences and support for WAST leaders and managers through a refreshed Leadership and Management Development Plan.	Q1	Q4	G
		Actively support Board and Board development activities so Non-Executive Directors feel confident to role model the new WAST behaviours.	Q1	Q4	G

Prog Ref.	Deliverable 2021-24	Actions in 2022-23	Start	End	Q1 Status
Innovation & Technology AH, EH, DR	We will improve access to, and availability of services via the 111.wales website and other digital channels (NHS Wales App).	111 actions covered in G2C			
		ePCR / WEDS Integration			G
	Improved digital tools and services to empower our teams to do their best.	-Deliver the new Control Room Solution as part of ESMCP	Q1	Q2	A
		-Mobile Data Vehicle Solution	Q3	Q4	NS
	We will use modern technology to reduce repeat tasks and improve processes.	-Robotic Process Automation Pilot	Q1	Q4	G
		-Pilot Microsoft Viva as part of the national centre of excellence.	Q1	Q4	A
		Standardised information architecture and common approach to data and analytics across the organisation.	-Deliver a modernised, more stable data warehouse .	Q2	Q2
	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation.	-Simplify the number of reporting tools and improve access and availability.	Q1	Q4	G
		-Deliver our part of the National Data Resource Programme .	Q1	Q4	G
	Improved resilience, flexibility and interoperability for the 999 call platform.	-Develop a forecasting and modelling framework	Q1	Q2	A
		-999 Platform upgrade	Q4	Q4	NS
	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation	-Digital Strategic Outline Case	Q4	Q4	NS
		-Consolidate and further enhance our relationships with higher and further education and commercial partners to build on our UTS status bid	Q1	Q4	G
		-Increase opportunities for patients and the public to participate in research	Q2	Q4	NS
		-Build our research community, attracting and deploying appropriately skilled staff	Q3	Q4	NS
-Seek out new partnerships and emerging opportunities to conduct innovative research		Q1	Q4	G	
-Align our research, innovation and transformation activity to best support our strategic ambitions		Q2	Q4	NS	
Infrastructure CT	We will deliver the Estates Strategic Outline Plan	Develop OBC for Swansea MRD Replacement (AWC)	Q1	Q4	G
		Development of business case for Llanelli solution (AWC)	Q1	Q4	A
		Development of business case for Newport solution (AWC)	Q1	Q4	A
		Development of business case for Llandrindod Wells (AWC)	Q1	Q4	A
		Development of business case for Bangor Fleet Workshop (AWC)	Q3	Q4	NS
		Full Business Case for the South East Fleet Workshop solution (AWC)	Q1	Q2	G
		Consider implications of NEPTS D&C Review and alignment with SOP	Q1	Q4	G
		Develop a permanent solution for challenges of increased numbers and poor estate condition in the north of Anglesey (Amlwch) (DC)	Q1	Q3	G
		Develop long term solution for EMS CCC at Llangunnon (DC)	Q1	Q3	G
		Implement a permanent solution for Ruthin working with Fire and Rescue partners (DC)	Q1	Q4	G
		Complete the redevelopment of VPH as an Operational Hub including enhanced facilities for CCC staff	Q1	Q3	G
		Secure additional resources for further implementation of Transition Plan arrangements (if required)	Q1	Q2	A
		Implement a permanent solution for EMS/NEPTS in Dolgellau (DC)	Q1	Q3	G
		Implement a medium term solution for NEPTS in Bridgend (DC)	Q1	Q3	G
	Implement a solution for NEPTS in Crosshands (DC)	Q1	Q3	G	
	We will implement the Environmental and Sustainability Strategy	Implement our Carbon Reduction Plan looking forward to 2025-2030	Q1	Q4	G
		Further progression of the decarbonisation agenda	Q1	Q4	G
		Develop an Electric Vehicle Strategy including a charging network	Q1	Q4	G
		Modernise our fleet including the increase in the number of Hybrid vehicles and roll out of vehicle solar panels.	Q1	Q4	G
		Access further funding to support decarbonisation of the estate and our travel which will enable us to implement a Sustainable Travel Plan	Q1	Q4	A
Develop work packages arising from the condition surveys		Q1	Q4	A	
Deliver the Fleet SOP	Development of an Infrastructure and Sustainability Strategic Outline Process and recruitment to support this.	Q1	Q4	A	
	Deliver the vehicle replacement scheme as per the 2022/23 Business Justification Case	Q1	Q4	G	

Prog Ref.	Deliverable 2021-24	Actions in 2022-23	Start	End	Q1 Status
Strategic Development	We will engage with a range of stakeholders, developing genuine pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum	Refresh and embed the brand and positioning of our 111 service, reflecting the completion of its roll-out across Wales	Q1	Q4	G
		Undertake a reputation audit as part of the strategic development programme	Q1	Q4	G
		Engage on the "Purpose" of the organisation	Q1	Q4	G
	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)	•Engage with stakeholders on our emerging long term strategic direction in line with a refreshed engagement framework	Q1	Q4	G
		•Agree a programme plan for the 'inverting the triangle' model, including governance structures, project resources, and broad timelines for delivery	Q1	Q4	G
		•Implement year 1 actions from the 'inverting the triangles' programme	Q1	Q4	G
Fundamentals	We will secure and implement Quality Management and control systems	Embed the Trust Quality Management System (QMS), evaluate and mature	Q1	Q4	G
		Evaluate the Trust Quality Governance Sub-structure to our Quality, Experience and Safety Committee (QuES)	Q1	Q2	G
		Implement the "Working Safely" Health and Safety Transformation Plan, incorporating Health, Safety & Wellbeing and Infection Prevention & Control	Q1	Q4	G
	We will transform the way we work and engage with people	Implementation of the Once for Wales Service User Experience System	Q1	Q1	A
		Continued development of the People & Community Network	Q1	Q4	G
	We will revisit and implement the Public Health Plan	Review and redraft the Public Health Plan in light of COVID and the health inequalities that have arisen as a result.	Q1	Q2	A
		Scope the opportunity to work in partnership with PHW and Velindre Trust on a joint appointment to lead the plan.	Q1	Q2	P
		Scope utilising the 111 website for public health messaging in partnership with PHW	Q1	Q4	P
	We will implement the Clinical Strategy to support developments across our service ambitions	Review the strategy to incorporate activity related to "inverting the triangle" and Clinical Leadership	Q1	Q4	
		Continue the delivery of the Clinical Strategy through the Clinical Transformation Programme Board	Q1	Q3	
	We will deliver a value-based approach	Work with the NCCU and Finance Delivery unit to develop a strategy and approach to Value-Based healthcare which links outcomes, patient experience and use of resources	Q1	Q4	G
		Improvement in ability to identify areas of unwarranted variation in service delivery across Wales, utilising PLICS	Q1	Q4	G
	We will deliver strong risk management processes and embed an enterprise wide risk culture that underpins the principles of good governance	Implement the new Once for Wales Datix Risk Module	Q1	Q3	A
		Undertake a detailed review of each Corporate Risk strengthening the articulation and management	Q2	Q4	G
		Development of a Risk Management Policy	Q3	Q3	NS
		Refresh of the Risk Management Strategy and procedures	Q3	Q3	NS
		Board education on Risk Management and development of Risk Appetite Statements	Q1	Q4	G
		Develop a new BAF	Q4	Q4	NS
		Develop and deliver a programme of training and education for the organisation	Q1	Q4	G



AGENDA ITEM No	10
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	4

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

MEETING	Finance & Performance Committee
DATE	18 th July 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk, Deputy Board Secretary
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide an update to Members in respect of activity relating to the Trust’s Corporate Risks relevant to the Committee’s remit.
2. In addition, it provides an overview of the progress in respect of the Risk Transformation Programme which was supported as the direction of travel at the Audit Committee in December 2021 and has been included in the Integrated Medium Term Plan (IMTP) (2022/25).

RECOMMENDATION:

3. **Members are asked to consider the contents of the report and:**
 - a. **Discuss the risks relevant to Committee.**
 - b. **Note the improved Board Assurance Framework.**
 - c. **Note the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors.**
 - d. **Note the 2022/23 Risk reporting timetable.**

KEY ISSUES/IMPLICATIONS

4. This paper sets out the outcome of the work that has been undertaken to date to strengthen and rearticulate the Trust’s Corporate Risks, relevant to Committee, including new titles, summary descriptions and scores which Members are asked to note.
5. A review of each Corporate Risk score has been undertaken by mapping each control to related assurances and by identifying any gaps in these as well as any actions that can be taken to further mitigate the risk. As a result of this, 1 score has increased.
6. Members are asked to note the risk reporting timetable approved by Audit Committee.

7. The new nationally agreed Risk Matrix is included in this paper for information.
8. The Executive Management Team (EMT) received formal, monthly feedback from the Assistant Director Leadership Team (ADLT) on activity relating to the corporate risks for approval.

REPORT APPROVAL ROUTE

9. The report has been considered by:
 - ADLT – 21st March 2022
 - ADLT – 22nd April 2022
 - EMT – 11th May 2022
 - Audit Committee – 7th June 2022

REPORT ANNEXES

10. SBAR report.
11. Annex 1 - Summary table describing the Trust's Corporate Risks.
12. Annex 2 - Risk Matrix
13. Annex 3 – Risk Reporting Timetable
14. Annex 4 - Board Assurance Framework

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

RISK MANAGEMENT & BOARD ASSURANCE FRAMEWORK REPORT

SITUATION

1. The purpose of this report is to provide an update in relation to the Trust's Corporate Risks, relevant to Committee, with a particular focus on the work that has taken place to rearticulate and strengthen these.
2. A summary report describing each of these corporate risks as of 12th May 2022 is detailed in Annex 1 as an extract from the Corporate Risk Register (CRR).
3. The approved National Risk Matrix is included in Annex 2 for Members information.
4. A Risk Reporting Schedule is included in Annex 3 for information.
5. The improved Board Assurance Framework (BAF) report is included in the paper in Annex 4.

BACKGROUND

6. The Risk Management and Board Assurance Framework Transformation Programme was supported as the direction of travel at the Audit Committee in December 2021 and has been included in the IMTP. A progress report was submitted to the Audit Committee meeting in June 2022.
7. The immediate priority was for a detailed review of the Trust's 5 highest scoring risks with the remaining corporate risks to follow. A programme of work has been undertaken to strengthen the articulation of each of the corporate risks and any new risks including title, summary descriptions, controls, assurances and any gaps or additional actions required.
8. The Assistant Directors Leadership Team (ADLT) continue to review the risk assessments, which have been approved by the Risk Owner, on all new risks in addition to reviewing any changes to existing risks and mitigating actions, reporting activity to the Executive Management Team (EMT), Board Committees and Trust Board.

ASSESSMENT

9. There are currently 16 Corporate Risks on the register, 9 of which are assigned to FPC for oversight, and these are described in the summary table in Annex 1. The table sets out the rearticulation of each of the Corporate Risks including new titles and summary descriptions, utilising an '*if, then, resulting in*' approach, the Executive Owner of the Risk and the Risk score with any changes that have occurred during the period.

Highest Scoring Risks

10. The immediate priority of the transformation programme was to undertake a full review of the Trust's highest scoring risks: Risks 223, 224, 199, 316 and 160 which has been completed. New titles were determined, and the risks clearly articulated with new summary descriptions. The controls and assurances have been mapped together and any gaps identified. Further actions have been identified to mitigate the risks in addition to reviewing the scores and controls rating assurances.
11. The same process has been applied to the remaining Corporate Risks on the CRR and these are described in the table in Annex 1 focussing on titles, summary descriptions and scores only. The full Risk detail, including controls, assurances, gaps and mitigating actions form part of the improved Board Assurance Framework (BAF) detailed in Annex 4; however, whilst significant progress has been made, this work is not fully complete with a number of risks still a work in progress.
12. The EMT has approved the rearticulation of each of the Corporate Risks, which are included in the summary table in Annex 1.

Closure and De-Escalation of Risks

13. No risks have been closed from the CRR or de-escalated to Directorate Registers since the last meeting.

Changes to Risk Scores

14. Members are asked to note that 1 Corporate Risk score has increased due to the rearticulation of the risks and subsequent review of the controls, assurances, gaps and mitigating actions.
15. This is Risk 245 and is described below. To support this, the new nationally agreed Risk Matrix is included in Annex 2; however, the rationale for the change, made by the Risk Owner, is described below.
16. **Risk 245** - *Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations.*

***IF** CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident*

***THEN** there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation, and facilities*

***RESULTING IN** potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005).*

17. The Risk Owner and ADLT recommended the risk score be increased to 16 (4x4) from 15 (3x5) given the potential impact on patients and staff. The increase in score was approved by the EMT.

Further Review of Risks

18. Work is ongoing to consider and develop potential new Risks for inclusion on the CRR and consideration will be given during the coming weeks to the following:
 - *Patient Safety/Putting Things Right Team*
 - *NHS Decarbonisation*
 - *Supply Chain Issues – Digital Equipment*
 - *Securing Stakeholder Support to Deliver the Strategy and IMTP*
 - *Capacity to deliver change (IMTP)*
 - *Ongoing Impact of CoVID and Increasing Demand for Services (IMTP)*
 - *Staff health and wellbeing in the face of continued pressure (IMTP)*

Board Assurance Framework

19. One element of the Risk Transformational Programme was to develop a transitional BAF that focusses the Board on the key risks that are mapped to the IMTP deliverables and that might compromise the achievement of the Trust's strategic objectives. Until such time as the more mature and strategic BAF is developed during 2023/24 as part of the transformational programme, these key risks are the corporate risks due to their relationship to the IMTP delivery and their risk ratings.
20. This BAF was presented to Audit Committee in June 2022 and will be presented to the Trust Board and each of the Committees as a standing Agenda item throughout the reporting cycles.

National Approach and Risk Matrices

21. Members are asked to note the new nationally agreed Risk Scoring Matrices (Annex 2). These have been developed in partnership across Health Boards and Trusts to align the approach to Risk Management across the NHS in Wales wherever possible.

Reporting Timetable

22. Members are asked to note the agreed risk reporting timetable described in annex 3.
23. Each of the red and high scoring risks will be reviewed monthly by the Risk Owners with the support of the Risk Team as part of the agreed review frequency matrices; however, these will be reported to Trust Board on a quarterly basis and any additional actions included where possible.

RECOMMENDED:

24. **Members are asked to consider and discuss the contents of the report and:**
 - a. **Discuss the risks relevant to Committee.**
 - b. **Note the improved Board Assurance Framework.**
 - c. **Note the adoption of the new nationally agreed Risk Matrix including scoring levels, review schedules and risk descriptors.**
 - d. **Note the 2022/23 Risk reporting timetable.**




Annex 1 – Corporate Risk Register Summary

CORPORATE RISK REGISTER				
RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
139	<p>Failure to Deliver our Statutory Financial Duties in accordance with legislation</p> <p>Previous title: <i>Non Delivery of Financial Balance</i></p>	<p>IF the Trust does:</p> <ul style="list-style-type: none"> not achieve financial breakeven and/or does not meet the planning framework requirements and/or does not work within the EFL and/or fails to meet the 95% PSPP target and/or does not receive an agreement with commissioners on funding (linked to 458) <p>THEN there is a risk that the Trust will fail to achieve all its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)</p> <p>RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage</p>	Director of Finance & Corporate Resources	<p>16 (4x4)</p> <p>➔</p>
244	<p>Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service</p> <p>Previous title: <i>Impact on EMS CCC service delivery due to estates constraints</i></p>	<p>IF the Trust is unable to increase accommodation capacity</p> <p>THEN there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives</p> <p>RESULTING IN EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience</p>	Director of Operations	<p>16 (4x4)</p> <p>➔</p>
245	<p>Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of</p>	<p>IF CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident</p>	Director of Operations	<p>16 (4x4)</p> <p>⬆</p>

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
	<p>Statutory Business Continuity regulations</p> <p>Previous title: <i>Inability to maintain safe and effective services during a disruptive challenge due to insufficient capacity in EMS CCCs</i></p>	<p>THEN there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities</p> <p>RESULTING IN potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)</p>		<p>New Score Up from 15 (3x5)</p>
311	<p>Inability of the Estate to cope with the increase in FTEs</p> <p>Previous title: <i>Failure to manage the cumulative impact on estate of the EMS Demand & Capacity Review, the NEPTS Review and GUH</i></p>	<p>IF the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed</p> <p>THEN there is a risk that the Estate will not be able to cope with the increase in FTEs</p> <p>RESULTING IN potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust</p>	Director of Finance & Corporate Resources	<p>16 (4x4)</p> <p style="font-size: 2em;">➔</p>
458	<p>A confirmed commitment from EASC and/or Welsh Government is required in relation to funding for recurrent costs of commissioning</p> <p>Previous title: <i>Confirmed commitments from EAST and/or Welsh Government required regarding funding for recurrent costs of commissioning to deliver the IMTP and/or additional services</i></p>	<p>IF sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis</p> <p>THEN there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients.</p> <p>RESULTING IN patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory</p>	Director of Finance & Corporate Resources	<p>16 (4x4)</p> <p style="font-size: 2em;">➔</p>

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
		obligations causing reputational damage		
260	<p>A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems</p> <p>Previous title: <i>Cyber Risk</i></p>	<p>IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place</p> <p>THEN there is a risk of a significant information security incident</p> <p>RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life</p>	Director of Digital Services	<p style="text-align: center;">15 (3x5)</p> <p style="text-align: center;"></p>
100	<p>Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience</p> <p>Previous title: <i>Failure to collaborate, engage and reach agreement with EASC on ambitions and plans for WAST</i></p>	<p>IF WAST fails to persuade EASC/Health Boards about WAST ambitions</p> <p>THEN there is a risk of a delay or failure to receive funding and support</p> <p>RESULTING IN a catastrophic impact on services to patients and staff and key outcomes within the IMTP not being delivered</p>	Director of Strategy Planning & Performance	<p style="text-align: center;">12 (3x4)</p> <p style="text-align: center;"></p>
283	<p>Failure to implement the EMS Operational Transformation Programme</p> <p>Previous title: <i>EMS Demand & Capacity Review Implementation Programme</i></p>	<p>IF there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme</p> <p>THEN there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters</p> <p>RESULTING IN potential patient harm, deterioration in staff wellbeing and reputational damage</p>	Director of Strategy Planning & Performance	<p style="text-align: center;">12 (3x4)</p> <p style="text-align: center;"></p>

CORPORATE RISK REGISTER

RISK ID	NEW RISK TITLE	NEW SUMMARY DESCRIPTION	EXECUTIVE OWNER	RISK SCORE
424	Prioritisation or Availability of Resources to Deliver the Trust's IMTP <i>Previous title: Resource availability (capital) to deliver the organisation's IMTP</i>	<p>IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)</p> <p>THEN there is a risk that there is insufficient capacity to deliver the IMTP</p> <p>RESULTING IN delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing</p>	Director of Strategy Planning and Performance	12 (3x4)

Annex 2 – Agreed National Risk Matrix begins at the top of the next page (17)

Consequence:	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Safety & Well-being - Patients/ Staff/Public	Minimal injury requiring no/minimal intervention or treatment. No time off work. Physical injury to self/others that requires no treatment or first aid. Minimum psychological impact requiring no support. Low vulnerability to abuse or exploitation - needs no intervention. Category 1 pressure ulcer.	Minor injury or illness, requiring minor intervention. Requires time off work for >3 days Increased hospital stay 1-3 days. Slight physical injury to self/others that may require first aid. Emotional distress requiring minimal intervention. Increased vulnerability to abuse or exploitation, low level intervention. Category 2 pressure ulcer.	Moderate injury/professional intervention. Requires time off work 4-14 days. Increased hospital stay 4-15 days. RIDDOR/Agency reportable incident. Impacts on a small number of patients. Physical injury to self/others requiring medical treatment. Psychological distress requiring formal intervention by MH professionals. Vulnerability to abuse or exploitation requiring increased intervention. Category 3 pressure ulcer.	Major injury leading to long-term disability. Requires time off work >14 days. Increased hospital stay >15 days. RIDDOR Reportable. Regulation 4 Specified Injuries to Workers. Patient mismanagement, long-term effects. Significant physical harm to self or others. Significant psychological distress needing specialist intervention. Vulnerability to abuse or exploitation requiring high levels of intervention. Category 4 pressure ulcer.	Incident leading to death. RIDDOR Reportable. Multiple permanent injuries or irreversible health effects. An event which impacts on a large number of patients.
Quality/ Complaints/ Assurance/ Patient Outcomes	Peripheral element of treatment or service suboptimal. Informal complaint/inquiry.	Overall treatment/service suboptimal. Formal complaint (Stage 1). Local resolution. Single failure of internal standards. Minor implications for patient safety. Reduced performance.	Treatment/service has significantly reduced effectiveness. Formal complaint (Stage 2). Escalation. Local resolution (poss. independent review). Repeated failure of internal standards. Major patient safety implications.	Non-compliance with national standards with significant risk to patients. Multiple complaints/independent review. Low achievement of performance/delivery requirements. Critical report.	Totally unacceptable level or quality of treatment/service. Gross failure of patient safety. Inquest/ombudsman/inquiry. Gross failure to meet national standards/requirements.
Workforce/ Organisational Development/ Staffing/ Competence	Short-term low staffing level that temporarily reduces service quality (< 1 day).	Low staffing level that reduces the service quality.	Late delivery of key objective/service due to lack of staff. Unsafe staffing level (>1 day)/competence. Low staff morale. Poor staff attendance for mandatory/key professional training.	Uncertain delivery of key objective/ service due to lack/loss of staff. Unsafe staffing level (>5 days)/competence. Very low staff morale. Significant numbers of staff not attending mandatory/key professional training.	Non-delivery of key objective/service due to loss of several key staff. Ongoing unsafe staffing levels or competence/skill mix. No staff attending mandatory/professional training.
Statutory Duty, Regulation, Mandatory Requirements	No or minimal impact or breach of guidance/statutory duty.	Breach of statutory legislation. Reduced performance levels if unresolved.	Single breach in statutory duty. Challenging external recommendations/improvement notice.	Enforcement action. Multiple breaches in statutory duty. Improvement notices. Low achievement of performance/ delivery requirements. Critical report.	Multiple breaches in statutory duty. Zero performance rating. Prosecution. Severely critical report. Total system change needed.
Adverse Publicity or Reputation	Rumours. Low level negative social media. Potential for public concern.	Local media coverage - short-term reduction in public confidence/trust. Short-term negative social media. Public expectations not met.	Local media coverage - long-term reduction in public confidence & trust. Prolonged negative social media. Reported in local media.	National media coverage <3 days, service well below reasonable public expectation. Prolonged negative social media, reported in national media, long-term reduction in public confidence & trust. Increased scrutiny: inspectorates, regulatory bodies and WG.	National/social media coverage >3 days, service well below reasonable public expectation. Extensive, prolonged social media. MP/MS questions in House/Senedd. Total loss of public confidence/trust. Escalation of scrutiny status by WG.
Business Objectives or Projects	Insignificant cost increase/ schedule slippage.	<5 per cent over project budget. Schedule slippage.	5–10 per cent over project budget. Schedule slippage.	Non-compliance with national targets. 10-25 per cent over project budget. Schedule slippage. Key objectives not met.	>25 per cent over project budget. Schedule slippage. Key objectives not met.
Financial Stability & Impact of Litigation	Small loss. Risk of claim remote.	Loss of 0.1–0.25% of budget Claim less than £10,000.	Loss of 0.25–0.5% of budget. Claim(s) between £10,000 and £100,000.	Uncertain delivery of key objective. Loss of 0.5-1.0% of budget. Claim(s) between £100,000 and £1 million. Purchasers failing to pay on time.	Non-delivery of key objective. Loss of >1 per cent of budget. Failure to meet specification. Claim(s) >£1 million. Loss of contract/payment by results.
Service/ Business Interruption	Loss/interruption of >1 hour. Minor disruption.	Loss/interruption of >8 hours. Some disruption manageable by altered operational routine.	Loss/interruption of >1 day. Disruption to a number of operational areas in a location, possible flow to other locations.	Loss/interruption of >1 week. All operational areas of a location compromised; other locations may be affected.	Permanent loss of service or facility. Total shutdown of operations.
Environment/Estate / Infrastructure	Minimal or no impact on environment/service/property.	Minor impact on environment/ service/property.	Moderate impact on environment/ service/property.	Major impact on environment/ service/property.	Catastrophic impact on environment/service/property.
Health Inequalities/ Equity	Minimal or no impact on attempts to reduce health inequalities/improve health equity.	Minor impact on attempts to reduce health inequalities or lack of clarity on the impact on health equity.	Lack of sufficient information to demonstrate reducing equity gap, no positive impact on health improvement or health equity.	Validated data suggests no improvement in the health of the most disadvantaged, whilst supporting the least disadvantaged, no impact on health improvement and/or equity.	Validated data demonstrates a disproportionate widening of health inequalities, or negative impact on health improvement and/or equity.

Risk Scoring Matrix (Likelihood x Consequence = Risk Score)		Consequence:				
Likelihood:		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
1 Highly Unlikely: Will probably never happen/recur	Not for years	1	2	3	4	5
2 Unlikely: Do not expect it to happen/recur but it is possible	At least annually	2	4	6	8	10
3 Likely: It might happen/recur occasionally	At least monthly	3	6	9	12	15
4 Highly Likely: Will probably happen/recur, but not a persisting issue	At least weekly	4	8	12	16	20
5 Almost Certain: Will undoubtedly happen/recur, maybe frequently	At least daily	5	10	15	20	25

Annex 3 - Risk Reporting Timetable

	ADLT	EMT	Deadline for Papers	Audit Committee	FPC	QuEST	PCC
1	5th May 2022	11th May 2022	31st May 2022	7th June 2022	18th July 2022	11th August 2022	6th September 2022
2	8th August 2022	24th August 2022	8th September 2022	15th September 2022	19th September 2022	10th November 2022	29th November 2022
3	31st October 2022	9th November 2022	24th November 2022	1st December 2022	16th January 2023	9th February 2023	21st February 2023
4	23rd January 2023	8th February 2023	23rd February 2023	2nd March 2023	20th March 2023		

Risk Register locked and no further changes will be made apart from any amendments agreed at EMT.

No risk report to FPC on 14th November 2022 (duplicate of 19th September 2022 report).

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation			Date of Review:	01/04/2022	TREND	16 (4x4)
				Date of Next Review:	30/06/2022	➔	
IF the Trust does:	THEN there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage		Likelihood	Consequence	Score	
<ul style="list-style-type: none"> not achieve financial breakeven and/or does not meet the planning framework requirements and/or does not work within the EFL and/or fails to meet the 95% PSPP target and/or does not receive an agreement with commissioners on funding (linked to 458) 				Inherent 3	4	12	
				Current 4	4	16	
				Target 2	4	8	
IMTP Deliverable Numbers: 10, 18, 28, 30, 34, 35, 37,38							
EXECUTIVE OWNER	Director of Finance and Corporate Resources		ASSURANCE COMMITTEE	Finance and Performance Committee			
CONTROLS			ASSURANCES				
<ul style="list-style-type: none"> Financial governance and reporting structures in place Financial policies and procedures in place Budget management meetings Regular financial reporting to ADLT, EFG, EMT, FPC and Trust Board in place Welsh government reporting Monthly review of savings targets Regular review monitoring and challenge via WAST and CASC quality and delivery meeting with commissioners. Monthly ICMB (Internal Capital Monitoring Board) meetings to monitor and review progress against capital programme and engagement with WG and capital leads. PSPP monthly reporting and regular engagement with P2P colleagues and periodic Trust Wide communications Forecasting of revenue and capital budgets Business cases and benefits realisation (both revenue and capital) 			<p>Internal Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> 'a. Risk is reviewed quarterly at F&P and a report is submitted bi-monthly to Trust Board 'c. Diarised dates for budget management meetings d. Diarised dates for EFG and FPC and monthly reports f. ADLT monthly review h. Diarised dates for ICMB meetings with regular monthly reports i. Regular PSPP communications (Trust wide) on Siren j. Monthly monitoring returns to ADLT, EFG, EMT and FPC j. Reliance on available intelligence to inform future forecasting. k. Business cases – scrutiny and approval at senior management team which are submitted to ADLT, EMT, FPC prior to Trust Board for approval as appropriate according to value. <p>External Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> e. Monthly Monitoring Returns to Welsh Government g. EASC management meetings. Monthly meetings with EASC and DAG for NEPTS. h. Bi-monthly Capital CRL meetings with Trust and WG capital leads i. Regular P2P meetings diarised (bi-monthly) j. Monthly monitoring returns into Welsh Government <p>Independent (3rd Line of Assurance)</p> <ul style="list-style-type: none"> Internal audit reviews covering controls a – j External audit reviews covering controls a – j 				

Risk ID 139	Failure to deliver our Statutory Financial Duties in accordance with Legislation			Date of Review:	01/04/2022	TREND	16 (4x4)
				Date of Next Review:	30/06/2022	➔	
IF the Trust does:	THEN there is a risk that the Trust will fail to achieve all of its statutory financial obligations and the requirements as set out within the Standing Financial Instructions (SFIs)	RESULTING IN potential interventions by the regulators, qualified accounts and impact on delivery of services and reputational damage			Likelihood	Consequence	Score
			Inherent	3	4	12	
			Current	4	4	16	
			Target	2	4	8	
GAPS IN CONTROLS		GAPS IN ASSURANCE					
<ul style="list-style-type: none"> Lack of formalised service contracts between Commissioner and WAST as a commissioned body 		None identified					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Continuing negotiations with Commissioners		Director of Finance and Corporate Resources/ Director of Strategy Planning and Performance	31/03/23 – Checkpoint Date				
2. Embed a transformative savings plan and ensure organisational buy in		ADLT and Savings subgroup	31/03/23 – Checkpoint Date				
3. Embed value-based healthcare working through the organisation		Executive Management Team and Value Based Healthcare Group	31/03/23 – Checkpoint Date				
4. WIIN support for procurement, savings and efficiencies		WAST Improvement and Innovation Network group	31/03/23 – Checkpoint Date				
5. Foundational economy, Decommissioning and procurement to mitigate social and economic wellbeing of Wales		Estates, Capital and Fleet Groups, NHS Wales Shared Services Partnership	31/03/23 – Checkpoint Date				

Risk ID 244	Estates accommodation capacity limitations impacting on EMS Clinical Contact Centre's (CCC) ability to provide a safe and effective service		Date of Review:	03/05/2022		TREND ➔	16 (4x4)
			Date of Next Review:	30/05/2022			
IF the Trust is unable to increase accommodation capacity	THEN there is a risk that EMS CCC will not be able to accommodate all roles during periods of escalation and surge management or expand operations to support new initiatives	RESULTING IN EMS CCC being unable to deliver services effectively which adversely impacts on quality, safety and patient/staff experience		Likelihood	Consequence	Score	
			Inherent	5	4	20	
			Current	4	4	16	
			Target	3	4	12	
IMTP Deliverable Numbers: 1,5,9, 10,18, 28, 30, 34							
EXECUTIVE OWNER		Director of Operations	ASSURANCE COMMITTEE		Finance and Performance Committee		
CONTROLS		ASSURANCES					
<ul style="list-style-type: none"> a. Temporary call handling provision in Carmarthen b. Maximum use of space at the Bryn Tirion site c. Maximum use of space at the Vantage Point House (VPH) site d. Prioritisation of space utilisation for each shift by CCC management team and alignment to priorities associated with safe service delivery 		<p>Internal Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> a. Monitoring of Performance standards for call handling (daily) and dispatch (weekly) to identify impacts on service with further investigation on a monthly basis b. All desks have been realigned to 2m physical distancing as part of covid preparations c. Review of VPH undertaken – November 2021 Staffing levels are managed according to maximum desk space on each centre. In VPH, because of agile working there is capacity for non-dispatch functions. d. Business continuity tracker for staffing levels updated daily <p>External</p> <p>Not applicable</p>					
GAPS IN CONTROLS		GAPS IN ASSURANCE					
<ul style="list-style-type: none"> • Call handling provision is a short-term solution and not fully resilient • Lack of resilience in temporary accommodation may trigger risk if business continuity plans are invoked • Current social distancing plans for EMS CCC do not provide solutions for the dispatch environment in Carmarthen • Current social distancing plans for EMS CCC provide limited solutions for call handling and dispatch in Bryn Tirion • Current social distancing plans for EMS CCC provide limited solutions for dispatch environment in VPH. • Estates Strategy is silent on risk associated with CCC environment 		<ul style="list-style-type: none"> • Carmarthen solution for call handling is temporary • Reconfiguration work reviewed by architects during pandemic preparation and earlier have yet to be delivered. • Agile working solution would be compromised in an ICT outage and paper-based approach would be used 					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Review current estate to identify moderate workplans to maximise available capacity within existing estate.		Assistant Director of Operations – Integrated Care	30.09.22 – Checkpoint Date				
2. Develop digital solutions for remote supervision and clinical support to maximise virtual network of CCC reducing capacity required in existing sites.		EMS CCC Area Manager	30.06.22				
3. Option appraisal required to review options for increasing CCC capacity. This should be aligned to the HIW review recommendation for the North CCC estates strategy and expanding this to support the pan-Wales estates position.		Assistant Director – Capital & Estates	31.12.22 – Checkpoint Date				
4. Based on modelling data under D&C review explore any efficiencies that can be gained in CCC estates through revised dispatch models maximising use of digital technology		CCC SE Manager	30.06.22 - Checkpoint Date				

Risk ID 245	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations		Date of Review:	03/05/2022		TREND	16 (4x4)
			Date of Next Review:	26/05/2022		↑	
IF CCCs are unable to accommodate additional core functions and do not have alternative site arrangements in place in the event of a business continuity incident	THEN there is a risk that EMS CCCs cannot utilise other CCC's space, accommodation and facilities	RESULTING IN potential patient harm and a breach of the requirements of the Civil Contingencies Act (2004) and Contingency Planning Regulations (2005)		Likelihood	Consequence	Score	
			Inherent	3	5	15	
			Current	4	4	16	
			Target	2	4	8	
IMTP Deliverable Numbers: 1, 5, 9							
EXECUTIVE OWNER		Director of Operations	ASSURANCE COMMITTEE		Finance and Performance Committee		
CONTROLS		ASSURANCES					
<ul style="list-style-type: none"> a. Trust Business Continuity Procedure and Incident Response Plan b. National EMS CCC Business Continuity Plan (reviewed in March 2021) c. Clinical remote working arrangements d. Single instance CAD allowing virtualisation which enables staff to work anywhere e. ITK (Interoperability Toolkit) technology in place which provides connectivity with other UK ambulance Trusts. This is used on a daily basis 		<p>Internal Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> a. Debrief from significant business continuity incidents which are put into organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years and partial review annually unless there is a major learning point. This is currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing b. Business Continuity Plan is up to date and has been reviewed and is currently waiting sign off. Business continuity exercise undertaken on 9.03.22. c. SOP in place with respect to Clinical Remote Working – this is being reviewed at present moment d. CAD alerts if there are systems issues e. Monitoring undertaken locally at least weekly <p>E Not applicable</p>					
GAPS IN CONTROLS		GAPS IN ASSURANCE					
<ul style="list-style-type: none"> • If CAD is not functional then any impact of current controls would be negated by need to move physical staff 		<ul style="list-style-type: none"> • Business continuity plan requires increased duties for existing staff as a result of lack of physical accommodation (link to risk 244) 					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
TBC							

Risk ID 311	Inability of the Estate to cope with the increase in FTES			Date of Review:	20/05/2022	TREND ↓	9 (3x3)
				Date of Next Review:	26/05/2022		
IF the cumulative impact on the estate of the EMS Demand & Capacity Review and the NEPTS Review is not adequately managed	THEN there is a risk that the Estate will not be able to cope with the increase in FTES	RESULTING IN potential failure to achieve the benefits/outcomes of the programme and reputational damage to the Trust		Likelihood	Consequence	Score	
			Inherent	4	4	16	
			Current	3	3	9	
			Target	2	3	6	
IMTP Deliverable Numbers: 1,3, 9, 10, 17, 18, 28, 30, 34							
EXECUTIVE OWNER		Director of Finance and Corporate Resources		ASSURANCE COMMITTEE		Finance and Performance Committee	
CONTROLS				ASSURANCES			
<ul style="list-style-type: none"> a. Programme governance and reporting structures in place e.g. Estates SOP Delivery Group and EMS Operational Transformation Programme Board, Integrated Strategic Planning Group Technical subgroup b. "Mega" spreadsheet combining all information into total cumulative impact on estate (and fleet) held by Assistant Director, Commissioning and Performance c. Programme risk register sits with EMS Programme Board. d. Risk logs held with respect to delivery of aspects of the project e. Project Manager in place (for delivery of the solutions identified) f. Interim estates solution project g. Finance and Corporate Resources directorate delivery plan 				Internal Management (1st Line of Assurance) <ul style="list-style-type: none"> a. Highlight report goes to Estates SOP Delivery Group every other month, report to EMS Operational Transformation Programme Board every 6 weeks, Technical Group meet monthly and there is an agenda, minutes and an action log b. Information is sense checked by AD Commissioning and Performance and reviewed by Integrated Technical Planning Group c. On agenda of meetings of Board d. Regional meetings are held regularly, and projects are discussed e. This resource is allocated to projects f. Same as d g. Reports go every 6 weeks to the Strategic Transformation Board External Not applicable			
GAPS IN CONTROLS				GAPS IN ASSURANCE			
<ul style="list-style-type: none"> • NEPTS D&C Review – Ambulance Care Programme Board • NEPTS Covid recovery planning • Finance may be a constraint to delivery of solutions when problem is identified 				<ul style="list-style-type: none"> • Information is received in an ad hoc and fragmented manner as opposed to a regular method from Operations 			
Actions to reduce risk score or address gaps in controls and assurances				Action Owner	By When/Milestone	Progress Notes:	
1. NEPTS and EMS – confirmation required from Operations functions about current and future numbers				Senior Management within Operations, Workforce & OD, Strategy Planning & Performance	31.12.22 – Checkpoint Date		
TBC							

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems		Date of Review:	19/04/2022		TREND	15 (3x5)
			Date of Next Review:	24/06/2022		➔	
<p>IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place</p>	<p>THEN there is a risk of a significant information security incident</p>	<p>RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life</p>		Likelihood	Consequence	Score	
			Inherent	4	5	20	
			Current	3	5	15	
			Target	2	5	10	
IMTP Deliverable Numbers: 7,8,9,10,12, 16,18,21,23, 24,25, 26, 38							
EXECUTIVE OWNER		Director of Digital Services	ASSURANCE COMMITTEE		Finance and Performance Committee		
CONTROLS			ASSURANCES				
<ul style="list-style-type: none"> a. Appropriate policy and procedures in place for Information/Cyber Security b. Trust Business Continuity Procedure and Incident Response Plan c. IT Disaster Recovery Plan d. Relevant expertise in Trust with respect to information security e. Data Protection Officer in post f. Cyber and information security training and awareness g. Mandatory Information Governance training which includes GDPR h. ICT tests and monitoring on networks & servers i. Information Governance framework j. Internal and NHS Wales governance reporting structures in place k. Checks undertaken on inactive user accounts l. Business Continuity exercises m. Operational ICT controls e.g. penetration testing, firewalls, patching n. Security alerts 			<p>Internal Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> a. Information Security Policy reviewed every 3 years (currently due for renewal). Incident Policy and Procedure put in place in February 2022 – renewed annually. b. Debrief from significant business continuity incidents captured within organisational learning spreadsheet. Governance with respect to this goes through SOTs. Full review of Incident Response plan every 3 years - currently undergoing a partial review. BCPs and BIAs should be reviewed annually by their owners. Annual schedule of testing c. Organisation-wide tabletop exercise undertaken in March 2022 with all BC leads and Digital teams. d. Staff undertake relevant training courses e.g. CISSP to increase knowledge and expertise e. In job description of Head of ICT f. Training statistics are available on ESR and from Phish threat module g. Training statistics reported on by Information Governance department h. Any issues would be identified and flagged and actioned i. WAST self-assesses its Information Governance Framework against the Welsh Information Governance toolkit. j. Internal WAST Information Governance Steering Group & All Wales Information Governance Management Advisory Group (IGMAG) meets quarterly, National Ambulance Information Governance Group (NIAG) meets every 2 weeks, Operational Security and Service Management Board (OSSMB) (national) – daily/weekly meetings and minuted meetings every 2 months. Minutes and actions logs available for meetings. k. Software in place to run check on inactive accounts as and when l. Annual schedule of testing m. Monthly scans on infrastructure. Penetration testing has occurred for different systems. 2 physical firewalls on networks to monitor traffic. Monthly patching occurs or as and when. n. Daily alerts are received. Anti-virus alerts received as and when threat discovered <p>External Independent Assurance</p> <ul style="list-style-type: none"> • NHS Wales Cyber Response Unit independent view of Network and Information Systems (NIS) Directive compliance within last 4 – 5 months (covering controls a, c – k, m – n) 				
GAPS IN CONTROLS			GAPS IN ASSURANCE				
<ul style="list-style-type: none"> • Not all information security procedures are documented • Lack of understanding and compliance with policy and procedures by all staff members • No organisational information security management system in place • IT Disaster Recovery Plan does not include a cyber response • Departments do not communicate in a timely manner with Digital Services around putting in new processes, new projects and procurement and this has a cyber security, information governance and resource impact 			<ul style="list-style-type: none"> • No regular Cyber/Info Security KPIs are reported to senior management committees • Cyber awareness campaigns could be undertaken more regularly e.g. bi-monthly 				
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When/Milestone	Progress Notes:		
1.Establish Cyber and Information Security KPIs			Director of Digital Services	31.08.22			

Risk ID 260	Significant and Sustained Cyber Attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems		Date of Review:	19/04/2022	TREND ➔	15 (3x5)
			Date of Next Review:	24/06/2022		
IF there is a large-scale cyber-attack on WAST, NHS Wales and interdependent networks which shuts down the IT network and there are insufficient information security arrangements in place	THEN there is a risk of a significant information security incident	RESULTING IN a partial or total interruption in WAST's ability to deliver essential services, loss or theft of personal/patient data and patient harm or loss of life		Likelihood	Consequence	Score
			Inherent	4	5	20
			Current	3	5	15
			Target	2	5	10
2. Discuss how cyber risk is reviewed and frequency of review		Director of Digital Services	31.08.22 – Checkpoint Date			
3. Suite of business continuity exercises that departments can undertake to test their plans to be provided.		North Resilience Manager	31.12.22			
4. Exercise template report which shows recommendations to be created		North Resilience Manager	31.12.22			
5. Formalise Cyber Incident Response Plan		Head of ICT	31.12.22 – Checkpoint Date			
6. Implement Meta Compliance Policy Solution		Senior ICT Security Specialist	31.12.22 – Checkpoint Date			

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services		Date of Review:	17/03/2022	TREND ➔	16 (4x4)
			Date of Next Review:	30/06/2022		
IF sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis.	THEN there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients.	RESULTING IN patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage		Likelihood	Consequence	Score
			Inherent	3	4	12
			Current	4	4	16
			Target	2	4	8
IMTP Deliverable Numbers: 2, 12, 16, 18, 23, 24, 25, 26, 28,30, 34, 37, 38						
EXECUTIVE OWNER		Director of Finance and Corporate Resources		ASSURANCE COMMITTEE		Finance and Performance Committee
CONTROLS			ASSURANCES			
<ul style="list-style-type: none"> a. Financial governance and reporting structures in place b. Financial policies and procedures in place c. Setting and agreement of recurrent resources d. Budget management meetings e. Budget holder training f. Annual Financial Plan 			Internal Management (1st Line of Assurance) <ul style="list-style-type: none"> a. Risk is reviewed quarterly at F&P and a report is submitted bimonthly to Trust Board d. Diarised dates for budget management meetings. If an area is in financial deficit, the meeting would be at least once a month. If the area is in balance or surplus, the meeting would be quarterly. e. Diarised dates for budget holder training 			

Risk ID 458	A confirmed commitment from EASC and/or Welsh Government is required in relation to funding of recurrent costs of commissioning services to deliver the IMTP and/or any additional services		Date of Review:	17/03/2022	TREND	16 (4x4)	
			Date of Next Review:	30/06/2022	→		
IF sufficient recurrent funding is not forthcoming there is a risk that the Trust will be committed to additional expenditure through delivery of the IMTP and in year developments which are only recognised by commissioners on a cost recovery basis.		THEN there is a risk that the Trust may not be able to deliver services and there will be a lack of funding certainty when making recurrent cost commitments. Any potential 'exit strategies' from developed services could be challenging and harmful to patients.	RESULTING IN patients not receiving services, the Trust not achieving financial balance and a potential failure to meet statutory obligations causing reputational damage		Likelihood	Consequence	Score
			Inherent	3	4	12	
			Current	4	4	16	
			Target	2	4	8	
g. Regular financial reporting to EFG & FPC in place h. Regular engagement with commissioners of Trust's services i. Welsh Government reporting on a monthly basis			f. Submission to Trust Board in March annually g. Diarised dates for EFG and FPC with full financial reports External Management (1st Line of Assurance) a. Accountability Officer letter to Welsh Government e.g. November 2021 c & h EASC management meetings. Monthly meetings with EASC and DAG meetings for NEPTS. Meetings are diarised i. Monthly monitoring returns Independent Assurance (3rd Line of Assurance) b. Internal Audit reviews of financial policies & procedures as part of their audit plan				
GAPS IN CONTROLS			GAPS IN ASSURANCE				
<ul style="list-style-type: none"> Lack of clarity regarding EASC/Welsh Government commitments with respect to recurrent funding 			<ul style="list-style-type: none"> Dialogue with EASC and DAG does not always result in recurrent arrangements (outside of WAST control) 				
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When/Milestone	Progress Notes:		
1. A formal approach to service change to be developed providing secure recurrent funding with commissioners.			Deputy Director of Finance	31.12.22			
2. Develop a Value Based Healthcare system approach with commissioners. This would mean that funding would flow more seamlessly between organisations and would go some way to mitigating the risk of not receiving recurrent funding.			Deputy Director of Finance	31.12.22			

Risk ID 100	Failure to persuade EASC/Health Boards about WAST's ambitions and reach agreement on actions to deliver appropriate levels of patient safety and experience		Date of Review:	20/05/2022		TREND	12 (3x4)
			Date of Next Review:	31/08/2022		➔	
IF WAST fails to persuade EASC/Health Boards about WAST ambitions	THEN there is a risk of a delay or failure to receive funding and support	RESULTING IN a catastrophic impact on services to patients & staff and key outcomes in the IMTP not being delivered		Likelihood	Consequence	Score	
			Inherent	4	4	16	
			Current	3	4	12	
			Target	2	4	8	
IMTP Deliverable Numbers: 2, 3, 4, 6, 11, 14, 29, 34							
EXECUTIVE OWNER		Director of Strategy Planning & Performance	ASSURANCE COMMITTEE		Finance and Performance Committee		
CONTROLS		ASSURANCES					
<ul style="list-style-type: none"> a. EASC/WAST Forward Plan b. EASC and its 2 sub-committees c. Weekly catch up between CASC/CEO d. Collaboration between EASC and WAST on specific projects e.g. Amber Review, EMS Operational Transformation Programme, Ambulance Care Programme e. Monthly CASC Quality and Delivery Meeting f. Patient Safety information e.g. Appendix B incidents, weekly/monthly patient safety reports 		<p>Internal & External Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> 'c. Meetings are diarised every week d. Representatives are co-opted onto meetings and frequency is between 3 – 6 weeks. Set agendas with NCCU reps co-opted. e. Formal meeting with agendas, minutes and action logs available. f. Information is going to Director of Quality and Nursing in Health Boards and other senior stakeholders <p>External Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> a. Plans go to every bi-monthly meeting b. Meet bi-monthly and agendas, minutes and action logs available 					
GAPS IN CONTROLS		GAPS IN ASSURANCE					
<ul style="list-style-type: none"> • WAST's ability to influence hospital handover delays (this is outside of the Trust's control and a Health Board responsibility) • Funding does not flow in a manner to balance demand with capacity (this is outside of WAST's control) 		<ul style="list-style-type: none"> • Health Boards are not sending Patient Safety Incidents that are National Reportable Incidents to the Delivery Unit (identified within a Delivery Unit audit) • Identified need for a governance meeting between NCCU and WAST to manage the overall commissioner/provider interface 					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Persuade EASC/Health Boards that sufficient funding to be provided to WAST		CEO WAST	30.06.22 – Checkpoint Date				
2. Persuade EASC/Health Board of the need for significant reduction in hospital handover hours		CEO WAST	30.06.22 – Checkpoint Date				
3. Increased understanding of NEPTS by EASC		Director of Strategy Planning and Performance	30.06.22 – Checkpoint Date				
4. Governance meeting between NCCU and WAST to manage the commissioner provider interface		Assistant Director Commissioning & Performance	30.06.22 – Checkpoint Date				

Risk ID 283	Failure to implement the EMS Operational Transformation Programme		Date of Review:	19/05/2022		TREND	12 (3x4)
			Date of Next Review:	31/08/2022		➔	
IF there are issues and delays in the planning and organisation of the EMS Demand & Capacity Review Implementation Programme	THEN there is a risk that WAST will fail to implement the EMS Operational Transformation Programme to the agreed performance parameters	RESULTING IN potential patient harm, deterioration in staff wellbeing and reputational damage		Likelihood	Consequence	Score	
			Inherent	4	4	16	
			Current	3	4	12	
			Target	2	4	8	
IMTP Deliverable Numbers: 3, 7, 17, 18, 19, 20, 27							
EXECUTIVE OWNER		Director of Strategy Planning & Performance	ASSURANCE COMMITTEE		Finance and Performance Committee		
CONTROLS		ASSURANCES					
<ul style="list-style-type: none"> a. Implementation Programme Board in place – meetings held every 3 weeks b. Executive sponsor and Senior Responsible Owner (SRO) for programme in place c. Programme Manager and Programme support office in place (for delivery of the programme) d. Programme risk register e. Assurance meetings held with Strategic Transformation Board (STB) every 6 weeks and with CEO every 3 weeks f. Programme budget in place g. Programme documentation and reporting is in place h. Regular engagement with the Commissioner and Trade Unions i. Management of external stakeholder and political concerns 		<p>Internal Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> a. Minutes and papers of Implementation Programme Board b. Project Initiation Document (PID) detailing structure and minutes of Implementation Programme Board c. Same as b d. Highlight reports showing key risks reported to STB every 6 weeks e. Highlight reports presented to STB every 6 weeks f. Programme budget monitoring report is provided to the Implementation Programme Board – every 6 weeks g. PID and Programme Plan Summary kept up to date. PID is presented to the STB if there is a significant change in the programme deliverables. Programme Plan Summary reported to the Implementation Programme Board every 3 weeks. h. Commissioner and TU participation at the Implementation Programme Board i. Communications and Engagement Plan sets out WAST's arrangements for engagement with stakeholders <p>External Management (1st Line of Assurance)</p> <ul style="list-style-type: none"> a. Deputy Ambulance Services Commissioner sits on the Implementation Programme Board b. Emergency Ambulance Service Committee Management Group receives a highlight report every two months e. EASC receives an update every 2 months on the programme as part of the WAST Provider Report 					
GAPS IN CONTROLS		GAPS IN ASSURANCE					
<ul style="list-style-type: none"> • Lack of workforce buy in due to changes in working practices • System pressures – patient handover delays at hospitals (link to risks 223 & 224) 		<ul style="list-style-type: none"> • Project Initiation Document (PID) needs to be updated to reflect 22/23 budget position • No prompts from STB for programme PID or risk register updates 					
Actions to reduce risk score or address gaps in controls and assurances		Action Owner	By When/Milestone	Progress Notes:			
1. Increase in engagement on the specifics of change at a locality level		Assistant Director – Commissioning & Performance	31.05.22 – Checkpoint Date				
2. More capacity requested (transition plan)		Assistant Director of Planning & Transformation	31.05.22 – Checkpoint Date				
3. Engage with key stakeholders to reduce handover delays		CASC	31.05.22 – Checkpoint Date				
4. Reduce abstractions in particular sickness absence		Deputy Director of Workforce & OD	30.09.22 – Checkpoint Date				
5. Engage with Assistant Director of Planning and Transformation on process for PID updates		Assistant Director – Commissioning & Performance	30.06.22 - Checkpoint Date				

Risk ID 424	Resource availability (capital) to deliver the organisation's Integrated Medium-Term Plan (IMTP)		Date of Review:	19/05/2022	TREND	12 (3x4)
			Date of Next Review:	31/08/2022	➔	
IF resources are not forthcoming within the funding envelope available to WAST (link to risk 139)	THEN there is a risk that there is insufficient capacity to deliver the IMTP	RESULTING IN delay or non-delivery of IMTP deliverables which will adversely impact on the Trust's ability to deliver its strategic objectives and improvement in patient safety and staff wellbeing		Likelihood	Consequence	Score
			Inherent	4	4	16
			Current	3	4	12
			Target	1	4	4
IMTP Deliverable Numbers: 5,9,10, 17, 28						
EXECUTIVE OWNER		Director of Strategy Planning & Performance	ASSURANCE COMMITTEE		Strategic Transformation Board Finance and Performance Committee	
CONTROLS			ASSURANCES			
<ul style="list-style-type: none"> a. Prioritisation of IMTP deliverables b. Financial policy and procedures c. Governance and reporting structures e.g. Strategic Transformation Board (STB) d. Assurance meetings with Welsh Government and Commissioners e. Transformation Support Office (TSO) which supports the major delivery programmes f. Project and programme management framework g. Regular engagement with key stakeholders 			Internal Management (1st Line of Assurance) <ul style="list-style-type: none"> a. Prioritisation detailed in IMTP and reviewed and agreed at Strategic Transformation Board 'c. IMTP sets out delivery structures and meeting minutes are available d. Agendas, minutes and slide decks available e. Paper on TSO to Strategic Transformation Board f. Powerpoint pack detailing PPM g. Stakeholder Engagement Framework E Independent Assurance (3rd Line of Assurance) <ul style="list-style-type: none"> 'b. Subject to Internal Audit 			
GAPS IN CONTROLS			GAPS IN ASSURANCE			
<ul style="list-style-type: none"> • Project and programme management (PPM) framework to be reviewed • Head of Transformation vacancy • Lack of a commercial contractual relationship with Commissioners (link to risk 458) 			<ul style="list-style-type: none"> • PPM needs to be reviewed and approved through STB • Benefits have not been fully linked to benefits realisation 			
Actions to reduce risk score or address gaps in controls and assurances			Action Owner	By When/Milestone	Progress Notes:	
1. Recruit a Head of Transformation			Assistant Director of Planning	30.09.22 – Checkpoint Date		
2. Review the PPM			Head of Transformation	31.03.23 – Checkpoint Date		
3. Develop Benefits Realisation plans in line with Quality and Performance Management framework			Assistant Director of Planning/Assistant Director, Commissioning & Performance	30.09.22 – Checkpoint Date		
4. A formal approach to service change to be developed providing secure recurrent funding with commissioners (link to risk 458)			Deputy Director of Finance	31.12.22		

IMTP Deliverable Key

No.	IMTP Deliverable
1	We will recover our systems of working and implement new ways of working developed during the pandemic as we learn to live with COVID-19
2	We will engage with a range of stakeholders, developing genuine Pan-Wales representation on partnership structures and delivering strong political and media relationships across the spectrum
3	We will develop and deliver a collaborative programme of work to design and implement new models within EMS (Inverting the Triangles)
4	We will work with partners to promote and expand use of 111 across Wales
5	We will increase the capacity and capability of the clinical teams for 111 and 999 callers, increasing clinical information available to them and we will create one integrated national team
6	We will work with partners to increase the number of seamless 24/7 pathways from the 111 clinical team to appropriate face to face consultations
7	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
8	We will increase accessibility, content and user experience of the 111 Digital front end, which can offer increasingly personalised advice
9	We will increase and balance response capacity and capability across urban and rural area of Wales
10	We will increase skill levels and resources (information, equipment and technology) available to clinicians on scene to allow them to most effectively assess and treat patients
11	We will work with partners to increase number of seamless 24/7 referral pathways as alternatives to ED conveyance and improve hospital handover
12	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
13	We will develop and deliver an improvement plan for NEPTS and increase capacity where required to meet demand
14	We will develop and implement with partners an-All Wales transfer and discharge service
15	We will continue to deliver against our Transport Solutions Programme to embed as a business-as-usual approach to service delivery
16	We will take steps to continuously improve the safety and quality of the service and provide an improved patient experience
17	We will improve resource availability, tackling absence and recruitment challenges to deliver improved performance
18	We will effectively manage risk, governance and compliance to promote and protect colleague and patient safety, and ensure a safe, productive and fair work environment
19	We will purposefully shape our future People and Culture Strategy to equip our people to thrive in a changing environment
20	We will foster a culture of belonging and wellbeing where our people can engage, feel supported and represented
21	We will improve access to, and availability of services via the 111 Wales website and other digital channels (NHS Wales app)
22	Improved signposting to the most appropriate service
23	Improved digital tools and services to empower our teams to do their best
24	We will use modern technology to reduce repeat tasks and improve processes
25	Standardised information architecture and common approach to data and analytics across the organisation

26	We will deliver greater insights to WAST and NHS Wales, through improved data sharing, analytics and visualisation
27	Improved resilience, flexibility and interoperability for the 999-call platform
28	We will provide an improved financial plan to support our ambitions
29	Finalise our organisational position on achieving University Trust Status (UTS) in collaboration with WG, embracing a culture of learning, research and innovation
30	We will deliver the Estates Strategic Outline Plan
31	We will implement the Environmental and Sustainability Strategy
32	Deliver the Fleet SOP
33	We will secure and implement Quality Management and control systems
No.	IMTP Deliverable
34	We will transform the way we work and engage with people
35	We will revisit and implement the Public Health Plan
36	We will implement the Clinical Strategy to support developments across our service ambitions
37	We will deliver a values-based approach
38	We will deliver strong risk management processes and embed a Trust-wide risk culture that embeds the principles of good governance



GIG
CYMRU
NHS
WALES

Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	11
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	0

Environment and Sustainability Update – July 2022
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MEETING	Finance & Performance Committee
DATE	18 th July 2022
EXECUTIVE	Chris Turley - Executive Director of Finance and Corporate Resources
AUTHOR	Richard Davies – Assistant Director of Capital and Estates Nicola Stephens – Environment and Sustainability Manager Jo Williams – Head of Capital Development
CONTACT	Nicola.stephens@wales.nhs.uk

EXECUTIVE SUMMARY

- To update the Committee in relation to the WAST Decarbonisation Action Plan (in response to Welsh Government’s NHS Wales decarbonisation strategic delivery plan (*NHSW- DSDP*)) and to outline the preparation for monitoring progress, linking with Welsh Government reporting requirements.
- To bring to the Committee’s attention risks in relation to delivery given funding and resource constraints
- To update the committee on work to progress with the roll out of 23 hybrid Rapid Response Vehicles and EV charging network

Recommendation – Committee to asked to note this update

KEY ISSUES/IMPLICATIONS

WAST Decarbonisation Action Plan update.

Following the approval of the Action Plan, and submission to Welsh Government alongside the IMTP, arrangements are now being progressed to establish a Programme Project Board and associated Project Teams, to oversee delivery of the plan and to ensure ownership of the actions across the Trust.

Initial Welsh Government scrutiny of the Action Plan for all NHS organisations has generated generic feedback, with some further WAST specific feedback being presented in a positive light and providing a helpful steer on some areas for further consideration in a future iteration. A Peer Review session is to be held on 12th July which will generate further commentary on the action plan, and this will be a useful opportunity to highlight WAST’s position in the national NHS context as an enabler for

change. Any further updates from this session will be provided to the Committee on 18th July.

From September 2022 Finance and Performance Committee will receive a regular report against progress with the action plan and this will consider support required to address key risks and barriers to delivery. It is anticipated that this will align with Welsh Government reporting requirements, which are also scheduled for September, and with ISO 14001 requirements.

A draft Terms of Reference is being prepared for the Programme Board; it is acknowledged that resource is required to give this work the necessary focus across the organisation, and progress has been made on recruitment of a project management resource which will commence in mid-August. In addition recruitment will shortly commence for an Environmental and Sustainability Officer within Capital and Estates.

It is acknowledged that the delivery of the Action Plan presents cost pressures which will need to be considered. Further scoping work has been done in support of the EV charging network which will be covered in further detail later in this paper. It is disappointing to note that a bid for £60k of Welsh Government funding, to support critical actions in support of scoping the infrastructure, has not initially been supported and now presents a further challenge to WAST's ability to deliver on a critical aspect of the action plan. Discussions do continue with WG officers as to whether there will be scope for this to be supported but if not, this further exacerbates the risk previously highlighted that the Trust will not be able to support the levels of investment required to achieve sufficient carbon reduction. As such, and as previously highlighted to Committee, and because of the risk of non-compliance to the NHSW-DSDP, a Risk Assessment has been completed and added to Trust's Corporate Risk Register.

WAST has previously responded to an all Wales Director of Planning led information gathering exercise on all Wales capital funding requirements over the next 10 years. The Trust has been very clear in its requirements around capital funding to support the decarbonisation agenda, acknowledging the significant investment which will be required to realise the ambitions for both fleet and estates across the organisation. Further feedback on the outputs and outcomes of that exercise is awaited from Welsh Government.

The central importance of WAST in delivering on key objectives of the NHS Wales plan, including our status as one of only two named organisations (alongside NWSSP) in the plan should not be underestimated. Without the support of Welsh Government, the wider NHS and partners, and the associated financial support, it will not be possible for WAST to deliver on expectations within the plan, nor on the specific actions agreed by the Trust for delivery of our own action plan. To further highlight this risk, an initial meeting is scheduled with Welsh Government's Deputy Director – Climate Change and Environmental Public Health, and a further joint meeting between WAST and WG officials will be scheduled for July/August. In the meantime, WAST continues to be represented at key national meetings and reinforces the support requirements.

The Committee has been receiving regular updates on the EFAB funded schemes being progressed. Whilst it is noted that this funding has not continued into 2022/23, the residual work on the projects from last financial year is nearing completion with

Porthcawl, Lampeter and Bargoed due for completion by end of July if supply chain risks do not occur.

Roll out of 23 hybrid Rapid Response Vehicles and EV charging network

Work continues on the infrastructure and Electric Vehicle (E.V) charging network which will support the roll out of WAST's EV fleet. Commencing in July 2022, upgrades to existing infrastructure and the installation of Podpoint chargers will support the roll out of 23 plug in hybrid RRVs and a small number of full electric fleet/MRD vans. The first 5 plug in hybrid RRVs are due to be operational by mid July.

It should be noted that wider review of the existing WAST estate to analyse the infrastructure available, capacity at sites, and a programme of works for the roll out of improvement works, including installation of chargers, will commence shortly. However, as noted above, resource to undertake this review is specialised and limited, and the bid to WG for £60k funding to support this has not been initially supported. The Trust therefore will need to consider the prioritisation of resources to support this work which is the key next step in determining the programme for infrastructure improvements.

Whilst the initial work has been led by Finance and Corporate Resources (Fleet, Finance, Capital and Estates), it is acknowledged that wider support from across the Trust will be required as the group works through a range of implications such as ICT, finance, counter fraud, health and safety, workforce and operational arrangements. A project board will be established once project management resource is available within the Capital and Estates team.

REPORT APPROVAL ROUTE

Finance & Performance Committee – 18th July 2022 – for noting

REPORT APPENDICES

None

REPORT CHECKLIST			
Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	n/a	Financial Implications	Y
Environmental/Sustainability	Y	Legal Implications	Y
Estate	Y	Patient Safety/Safeguarding	n/a
Ethical Matters	n/a	Risks (Inc. Reputational)	Y
Health Improvement	Y	Socio Economic Duty	Y
Health and Safety	Y	TU Partner Consultation	n/a



GIG
CYMRU
NHS
WALES | Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	
OPEN or CLOSED	Open
No of ANNEXES ATTACHED	3

AUDIT REPORT

MEETING	Finance & Performance Committee
DATE	18 th July 2022
EXECUTIVE	Trish Mills, Board Secretary
AUTHOR	Julie Boalch, Head of Risk and Corporate Governance
CONTACT	Julie.Boalch@wales.nhs.uk

EXECUTIVE SUMMARY

1. The purpose of the report is to provide the Finance & Performance Committee (FPC) with an update in relation to the outstanding recommendations from Internal Audit reviews.
2. In addition, the paper sets out the Internal Audit plan activity and includes copies of current and relevant Audit Reports that provide a fundamental line of assurance to the FPC.

RECOMMENDATION:

3. **The Finance & Performance Committee is asked to:**
 - a. **Note and consider the contents of the report,**
 - b. **Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to FPC, and**
 - c. **Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee**
 - d. **Receive the 3 Internal Audit Reports that were presented to the Audit Committee in June 2022.**

KEY ISSUES/IMPLICATIONS

4. The internal audit recommendations continue to be reviewed by the Assistant Directors Leadership Team (ADLT) and the Executive Management Team (EMT) to ensure that any new completion dates are assigned with realistic timescales and a strong narrative and rationale to support any extension.

REPORT APPROVAL ROUTE

5. The report has been submitted to:
 - ADLT – 26th June 2022

REPORT APPENDICIES

6. The Audit Tracker has been circulated as a separate document - Appendix 1.
7. Waste Management Internal Audit Report – Appendix 2.
8. Network & Information Systems Directive Internal Audit Report Appendix 3.
9. Service Reconfiguration Internal Audit Report – Appendix 4.

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	NA	Financial Implications	NA
Environmental/Sustainability	NA	Legal Implications	NA
Estate	NA	Patient Safety/Safeguarding	NA
Ethical Matters	NA	Risks (Inc. Reputational)	NA
Health Improvement	NA	Socio Economic Duty	NA
Health and Safety	NA	TU Partner Consultation	NA

**WELSH AMBULANCE SERVICES NHS TRUST
FINANCE & PERFORMANCE COMMITTEE
INTERNAL AUDIT TRACKER**

SITUATION

1. The purpose of this paper is to provide the Finance & Performance Committee (FPC) with an update in respect of recommendations resulting from internal audit reviews that are presented to the Committee for oversight.
2. In addition, the paper sets out the Internal Audit plan activity and includes copies of current and relevant Audit Reports that provide a fundamental line of assurance to the FPC.

BACKGROUND

3. The audit recommendation tracker is in place for the purpose of tracking progress across the Trust to ensure that recommendations contained in internal and external audit review reports are actioned and in a timely manner.
4. This tracker provides Senior Managers with a workable tool that allows for closer scrutiny of audit recommendations and is designed to provide a more detailed focus as to the reasons why recommendations are overdue or have not progressed within the agreed timeframes. This will highlight areas that may require additional support and ensures there are clear mechanisms in place to escalate any issues.
5. The Internal Audit plans have been developed in partnership with the Executive Management Team to identify current and emerging areas of risk, as well as specific assurance needs within the Trust.

ASSESSMENT

Internal Audit Plan 2021/22

6. There are 3 current internal audit reports relevant to the FPC which form part of the 2021/22 Internal Audit Plan. These reports were presented to the Audit Committee in June 2022 and are attached in the Appendices in relation to the following reviews:

Internal Audit Report	Assurance Rating	Date received/or due at Audit Committee
Network and Information Systems (NIS) Directive	Reasonable	June 2022
Service Reconfiguration	Reasonable	June 2022
Waste Management	Limited	June 2022

Internal Audit Plan 2022/23

7. There are 16 internal audit reviews relevant to the FPC which are included in the 2022/23 Internal Audit Plan as follows:

Internal Audit Report	Estimated Date of Audit	Date due at Audit Committee
Major incidents	Q1	September 2022
Estates Assurance - Decarbonisation	Q1	September 2022
Fleet Maintenance	Q1	September 2022
Electronic Patient Clinical Record	Q1	September 2022
Hazardous Area Response Team (HART)	Q2	December 2022
Immediate Release Request	Q2	December 2022
Data Analysis	Q2	December 2022
Standards of Business Conduct: Declarations	Q2	December 2022
Savings and Efficiencies	Q3	March 2023
IMTP Delivery	Q3	March 2023
Cyber Security	Q3	March 2023
Risk Management and Assurance	Q4	June 2023
Health & Safety (deferred from 2021/22)	Q4	June 2023
Strategy Development	Q4	June 2023
IM&T Infrastructure	Q4	June 2023
Follow Up Action Tracker	Q4	June 2023

Internal Audit Highlights

8. At the time of issuing the paper, there were a total of 95 current internal audit recommendations on the tracker. 27 recommendations were marked as complete at the June 2022 Audit Committee and removed from the tracker.
9. 33 recommendations were added to the tracker resulting from 7 Internal Audit Reports which were presented to the Audit Committee in June 2022. 16 of these recommendations were assigned to FPC and were from Reasonable and Limited Assurance rated reports as follows:
- Network & Information Systems Directive – Reasonable Assurance
 - Service Reconfiguration – Reasonable Assurance
 - Waste Management – Limited Assurance
10. The status of each of the current internal audit recommendations is described in the table below.

Status	Total Number of Recommendations on the tracker	Those directly relevant to FPC	High Priority FPC	Medium Priority FPC	Low Priority FPC
Overdue	49	27	3	18	6
Not yet due*	37	25	8	16	1
Complete	9	7	3	3	1
Total	95	59	14	37	8

* accepting extensions have been applied in line with the agreed pandemic arrangements.

11. Of the 3 high priority recommendations showing as overdue these relate to the 20/21 Clinical Contact Centres Performance Management Reasonable Assurance review, which are due to be completed between July and December 2022.

12. The total number of recommendations, separated by financial year, and status this period is described below.

Financial Year	Total Number of Recommendations on the tracker	Those directly relevant to FPC	Complete FPC	Overdue FPC	Not Yet Due FPC
2019/20	3	2	0	2	0
2020/21	15	15	1	14	0
2021/22	77	42	6	11	25
Total	95	59	7	27	25

13. Of the 27 recommendations that are showing as overdue, these relate to the following reports:

- 19/20 Information Systems Security Leavers Reasonable Assurance Follow Up Review
- 20/21 Clinical Contacts Centre Performance Management - Reasonable
- 20/21 111 Service Governance Arrangements - Reasonable
- 20/21 NEPTS Journey Booking - Reasonable
- 20/21 IM&T Control Risk Assessment - Not Rated
- 20/21 ICT Disaster Recovery – Limited
- 21/22 NEPTS Procurement – Reasonable
- 21/22 Service Management – Reasonable
- 21/22 Digital Governance - Reasonable
- 21/22 Service Reconfiguration - Reasonable

14. The number of recommendations by assurance rating and level of priority are detailed below.

Assurance Ratings	Total No. of Recommendations on the tracker	Those directly relevant to FPC	High Priority FPC	Medium Priority FPC	Low Priority FPC
Limited	12	12	8	4	0
Reasonable	77	45	6	33	6
Substantial	0	0	0	0	0
Not Rated	6	2	0	0	2
Total	95	59	14	37	8

15. Of the 12 Limited Assurance recommendations, 2 of these have been completed during the period, 9 are not yet due and 1 is overdue from the ICT Disaster Recovery review.

16. The Governance team continue to seek assurance from Senior Management relating specifically to each report that:

- Recommendations have been considered and completed within agreed timeframes and;
- All is being done to ensure that the follow up of recommendations will not result in further *Limited* or *No Assurance* rated reports.

RECOMMENDED:

- 17. The Finance & Performance Committee is asked to:**
 - a) Note and consider the contents of the report,**
 - b) Consider the Trust's proposals to address each recommendation with the inclusion of revised completion dates, specifically focussing on those relevant to FPC, and**
 - c) Agree any specific items that the Committee wishes to see raised to Senior Management and Audit Committee.**
 - d) Receive the 3 Internal Audit Reports that were presented to the Audit Committee in June 2022.**

Waste Management Final Internal Audit Report

May 2022

Welsh Ambulance Services NHS Trust

NWSSP Audit and Assurance

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Review reference:	SSU-WAST-2122-02
Report status:	Final
Fieldwork commencement:	4 th January 2022
Fieldwork completion:	7 th March 2022
Draft report issued:	18 th March 2022
Draft report meeting:	29 th April 2022
Management response received:	24 th May 2022
Final report issued:	25 th May 2022
Auditors:	NWSSP Audit & Assurance: Specialist Services Unit
Executive sign-off:	Executive Director of Finance and Corporate Resources Executive Director of Quality and Nursing
Distribution:	Assistant Director of Capital and Estates Head of Infection Prevention and Control Head of Capital Development Head of Risk/Deputy Board Secretary Environment & Sustainability Manager
Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with agreed audit brief, and the Audit Charter as approved by the Audit Committee.

Audit reports are prepared by the staff of the NHS Wales Shared Services Partnership – Audit and Assurance Services, and addressed to Independent Members or officers including those designated as Accountable Officer. They are prepared for the sole use of the Swansea Bay University Health Board and

no responsibility is taken by the Audit and Assurance Services Internal Auditors to any director or officer in their individual capacity, or to any third party.

Executive Summary

Purpose

The audit was undertaken to assess the Trust’s compliance with relevant waste management legislation and guidance, and progress towards agreed national and local waste reduction targets.

Overview

Whilst recognising the period of review was impacted by the Covid response, we identified several significant issues for reporting in our review, resulting in an overall Limited assurance.

Whilst it is recognised that the Trust’s total waste production is significantly lower than other NHS organisations, the Trust still has a duty of care for the waste it does produce.

The Trust acknowledges the need to clarify accountability around oversight and management of clinical waste within the organisation, and is currently completing an Organisational Change Process (OCP) through which this will be addressed.

Matters arising concerned the following:

- Once the OCP is completed there is an urgent need to review and update out of date waste management procedural guidance;
- The need to assign executive leadership, committee responsibility and operational responsibility for waste related matters;
- To confirm Natural Resources Wales approval of clinical waste arrangements – noting that Health Courier Services is no longer part of WAST and that the waste is transferred to non-WAST premises.
- The need to evidence ‘Duty of Care Transfer Notes’ for the transfer of Waste to other NHS organisations.
- To re-introduce Clinical Waste Duty of Care and Clinical Waste Pre-acceptance audits to inform internal reporting on waste.

Report Classification

Limited



More significant matters require management attention.

Moderate impact on residual risk exposure until resolved.

Assurance summary

Assurance objectives	Assurance
1 Policy & Procedures	Limited
2 Governance & Management	Limited
3 Contractual Arrangements	Limited
4 Operational Practice	Substantial
5 Monitoring & Reporting	Limited

The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion

Other recommendations are within the detail of the report.

Matters Arising		Assurance Objective	Control Design or Operation	Recommendation Priority
1.1 & 1.2	The Waste Process document requires update/ approval to comply with WHTM 07-01.	1	Design	High
2.1, 2.2 & 3	An Executive lead, committee responsibility and supporting operational responsibilities should be assigned for Waste related matters.	2	Operation	High
4	A formal training needs assessment to determine the training requirements across the Trust.	2	Operation	Medium
5.1	The Trust should review the arrangements in place for the transfer of clinical waste and gain assurance that the current relationship with HCS meets the legal responsibilities that are placed on WAST as the producer of clinical waste.	3	Operation	High
5.2	In addition the Trust should seek assurance from Natural Resources Wales that the change in arrangements with HCS continues to conform with the original ruling on waste transfer (and transfer notes).	3	operation	Medium
6	To obtain a duty of care transfer notes on an annual basis covering handover of clinical waste Health Boards.	3	Operation	High
7	Clinical Waste Duty of Care audits and Clinical Waste Pre-Acceptance audits should be completed as a matter of course.	5	Operation	High

1. Introduction

- 1.1 Welsh Health Technical Memorandum (WHTM) 07-01: '*Safe Management of Healthcare Waste*' provides a framework for best practice waste management, to help healthcare organisations meet legislative requirements as well as identify opportunities to improve waste minimisation and reduce the associated environmental and carbon impacts of managing waste.
- 1.2 Effective waste management also requires compliance with the requirements of various regulatory regimes, including environment and waste, controlled drugs, infection control, health and safety and transport.
- 1.3 Noting that waste arising from Covid-19 patients is designated as infectious clinical waste, specific guidance has additionally been developed in the last year ('Covid-19 waste management standard operating procedure').
- 1.4 The Welsh Government's waste reduction targets were set out in its 'Towards Zero Waste' strategy, first published in 2010 – with a target of 70% recycling / recovery rate by 2025, and for all waste to be recycled by 2050.
- 1.5 This audit assessed Welsh Ambulance Services NHS Trust's (the Trust) compliance with the relevant legislation and guidance, and progress towards agreed national and local waste reduction targets.
- 1.6 The potential risks considered in the review were as follows:
 - Safety of Trust staff, patients, visitors and contractors.
 - Environmental damage.
 - Non-compliance with legislation, risking financial penalties or prosecution.
 - Failure to achieve mandated waste reduction targets.
 - Reputational damage associated with negative publicity.
 - Failure to achieve value for money for the Trust.

2. Detailed Audit Findings

Policy & Procedures: To ensure an appropriate Waste Management Policy and supporting procedures were in place.

- 2.1 WHTM 07-01 requires, as a minimum, that a healthcare waste policy is signed off at Board level to demonstrate high level commitment. The Trust however do not have a formal policy on Waste Management instead utilising a Guidance Note. It is not clear when the Guidance Note was first approved or at which forum it was ratified, although it was due for review in October 2015, however it also notes this is version 1.2 amended September 2019 (see **MA1**).
- 2.2 Whilst the Guidance Note was found to cover much that the WHTM 07-01 requires, enhancements were required to ensure full compliance with the WHTM requirements and best practice.
- 2.3 Recognising the status of the Guidance Note, **limited assurance** has been determined.

Governance & Management: To ensure an appropriate governance structure was operating, budgets were appropriately monitored, risks recorded, monitored and escalated, and training appropriately delivered.

- 2.4 The Trust's Waste Guidance Note detailed that the National Estates Manager as the nominated General Waste and Recycling Manager, however there was no reference to Executive level responsibility within the Guidance Note (see **MA2**).
- 2.5 Operational responsibility for Clinical Waste at each site had also not been formally assigned, however it was advised that there is an Organisational Change Process currently underway and that this issue is to be addressed as part of this (see **MA2**).
- 2.6 The Trust did not have a dedicated waste forum and a review of the committee papers noted no reporting of waste issues. It is recognised that the Trust's total waste as reported for 2019/20 was only a tenth of that reported by some Health Boards for the same period. Regardless, waste matters should be subject to regular review and scrutiny by an appropriate committee/ group (see **MA 3**).
- 2.7 WAST are not part of the All-Wales Clinical Waste Consortium but a Trust representative did however attend meetings during the Covid Pandemic. Historically WAST's interests were represented by Health Courier Services (HCS) which were disaggregated from WAST in 2017 and are now part of NHS Wales Shared Services Partnership (NWSSP). HCS have continued to transport Clinical Waste from WAST sites to other Consortium member sites. This relationship is discussed further at the next section.
- 2.8 The Trust utilised on-line training through ESR which encompassed both Environmental and Waste training, Waste was also part of the standard induction training. Due to issues with the IT system which were beyond the control of WAST, no data was available for attendance/completion of waste related training for 2021/22 – accordingly, training compliance was not reported in the period (see **MA 4**).
- 2.9 A formal training needs assessment had not been undertaken to determine the wider training needs and responsibilities across the Trust. At the time of the audit fieldwork, there were no arrangements in place to deliver wider training to clinical and general staff, in respect of e.g. handling of clinical waste / recycling etc. (see **MA4**).
- 2.10 Noting the above, **limited assurance** has been determined in this area.

Contractual arrangements: Assurance that waste contracts were appropriately procured and were monitored against agreed performance targets. That appropriate controls operated in the payment of invoices.

- 2.11 The Trust's contractual arrangements for general waste / recycling was centrally procured and managed by NWSSP Procurement Services. The contract is currently in year 4 of 5.
- 2.12 Clinical waste is collected from Trust sites by Health Courier Services (HCS) and transferred to two locations, Mamhilad in Pontypool and NWSSP Denbigh Stores. From there it is collected by the waste contractor for incineration. Management advised that the Trust does not have a direct contractual relationship with the contractor, but it accesses the contract via HCS. The SLA put in place following the disaggregation of HCS in 2017 did not reference waste management arrangements. It is recommended that the Trust look at the revised arrangements to ensure that it continues to meet its full obligations, noting that it is unlikely to be able to rely on HCS as being part of WAST (see **MA5.1**).

- 2.13 In 2015, Natural Resources Wales agreed that HCS transfer notes were not required for collecting clinical waste from WAST sites. However, this refers back to a time when HCS was a part of WAST and the waste was being transferred from WAST Ambulance Stations to WAST premises. In the North, the waste is now taken to Denbigh Stores, which is a facility operated by NWSSP. It is concluded that Natural Resources Wales should be approached to reaffirm that the revised arrangements continue to comply (see **MA5.2**).
- 2.14 As part of operational practice Ambulances routinely decant clinical waste when visiting Hospitals to transfer patients – given the limited amount of clinical waste that can be physically stored on the vehicles. However, whilst noting that this is good practice, WHTM 07-01 goes on to note that *"where the WAST drops its waste off at a hospital, this is classed as waste transfer. Therefore, duty of care applies and the WAST should ensure that the appropriate agreements are in place to enable it to transfer its waste to the hospital"*.
- 2.15 WHTM-07-01 goes on to note that whilst waste transfer notes are not required, *"A duty of care transfer note is, however, required, although there are mechanisms to enable this to be done on an annual basis"*. No evidence was provided to demonstrate that WAST have obtained the (annual) duty of care transfer notes from the respective Health Boards. (**MA6**)
- 2.16 Noting the uncertainty about the current arrangements surrounding the transfer and ownership of clinical waste **limited assurance** has been determined.

Operational Practice: A review of operational arrangements in key areas such as segregation, storage, safe handling, transfer etc. and associated record keeping, to assess compliance with the Trust's policy and procedures, WHTM 07-01 and relevant legislation. A review of waste reduction initiatives pursued by the Trust.

- 2.17 Operational arrangements were observed at Rhyl Locality Ambulance Office & Station and Aberconwy Ambulance Station. The site visits incorporated a review of waste management arrangements in areas including main entrances, garage areas, staff rest areas, and the external waste compounds.
- 2.18 Good practice was observed in all areas reviewed, including the following:
- Appropriate provision of clearly labelled and suitable bins to facilitate correct segregation of waste at source;
 - Appropriate frequency of removal of waste from source to central holding areas, to prevent build-up of waste;
 - Appropriate labelling and packaging of waste in accordance with WHTM 07-01 requirements; and
 - Tidy and secure external compound areas for the holding of waste prior to collection.
- 2.19 Recognising the good practice observed in all areas of operational practice reviewed, with no non-compliances with WHTM 07-01 identified, **substantial assurance** has been determined in this area.

Monitoring & Reporting: Adequate arrangements were in place to record, monitor and report waste management activities, including incidents, compliance audits, costs and performance against agreed targets. That reporting was appropriately directed at both operational and executive level.

- 2.20 Appropriate arrangements had been determined for the recording and investigation of waste-related incidents. Management confirmed that no incidents had occurred during the last three years.

2.21 The Trust participates in several waste-related reviews each year, including:

- ISO14001 Environmental System external audit; and
- Annual internal Sustainability Management Review.

2.22 However, the Trust has not undertaken Clinical Waste Duty of Care audits (reviewing contractor practices); or Clinical Waste Pre-Acceptance audits (reviewing the segregation and handling of clinical waste on Trust premises). This is due to the historical arrangement that HCS transport clinical waste from WAST premises to central locations and that the clinical waste contract rests with HCS. A recommendation has been raised in respect of this (see **MA7**).

2.23 Prior to Covid-19, compliance audits were undertaken in respect of general waste and recycling, these were undertaken by the waste contractor and also by the Trust's Environmental and Sustainability Manager. These have not been conducted for 2 years, but Trust management advised these audits would be reinstated as soon as practicably possible (see **MA7**).

2.24 Separately, the handling of clinical waste is picked up as part of the Infection Prevention and Control Team audits, however these had similarly been affected by Covid with no audits undertaken during the pandemic. The Head of Infection Prevention and Control at The Trust advised that they are currently preparing a plan for this work to recommence

2.25 Noting issues within the Governance & Management section and the absence of independent assurances during the period, a **limited assurance** has been determined in this area.

Appendix A: Management Action Plan

Matter Arising 1: Policy & Procedures (Design)	Impact
<p>Welsh Health Technical Memorandum (WHTM) 7.1: <i>'Safe Management of Healthcare Waste,'</i> sets out the importance of a healthcare waste policy:</p> <p><i>"To effectively manage healthcare waste, all those involved in the management of the waste stream should have access to an appropriate healthcare waste policy that identifies who is responsible for the waste and provides clearly written instructions on how it should be managed"</i> (6.2);</p> <p>The Trust do not have a formal policy on Waste Management instead utilising a Guidance Note.</p> <p>It is not clear when the Guidance Note was first approved or at which forum it was ratified. Although it notes it was due for review in October 2015, it also notes this is version was amended in September 2019. Therefore, it would not appear to be compliant with the WHTM 07-1 which recommends that the policy should include:</p> <p><i>"a clear statement, outlining the aims and rationale of the policy, signed off at board level to demonstrate high-level commitment"</i> (6.4).</p> <p>Whilst the document was found to cover much that the WHTM 07-01 recommends, it was noted the following areas were not incorporated:</p> <ul style="list-style-type: none"> • Confirmation of Board-level Committee responsibility for waste management; • Document Executive Level Responsibility • Detail of contractual arrangements (including contingencies); • The process of identifying improvement programmes; • Detail regarding staff training arrangements. <p>It is recognised, that procedural guidance was clearly displayed on site (as confirmed during the site visits to Rhyl and Aberconwy Ambulance Stations), providing relevant instruction to staff at the point of waste disposal.</p>	<p>Potential risk of:</p> <ul style="list-style-type: none"> • Absence of Board-level commitment does not provide the Trust's approach with the support required;

Recommendations		Priority
<p>The Waste Process document review should be concluded as scheduled, with consideration given to the Policy guidance set out in WHTM 07-01, and with enhanced detail regarding governance structure and training arrangements.</p> <p>The Trust should ensure the Waste Process document, following review and update, is approved at the relevant Board-level Committee as a formal policy, in accordance with WHTM 07-01 requirements</p>		<p>High</p>
Agreed Management Action	Target Date	Responsible Officer

<p>Agreed as the key priority, recommendation and action for immediate further improvement from this review. From which the response and resolution for many of the other actions will naturally follow. To progress many of these, it has been jointly agreed at Exec level that a task and finish group (TFG) will be immediately created with representatives from the following departments</p> <ul style="list-style-type: none"> • Estates and Facilities • IPC • Health and Safety • Operations • ICT • Fleet • Corporate Services • Training • Finance • Medical directorate (for drug management issues) • Clinical equipment and logistics • TU rep <p>The TFG will develop a National Waste policy to cover both domestic waste and clinical waste. The policy will identify the management structure for both sections of waste (which will be different) and therefore a reporting structure, including through to Board Committees (likely to be by exception) and therefore Trust Board itself. It will also identify training needs and all compliance and audit obligations.</p>	<p>Immediate</p> <p>(Policy writing may take a few months and process to be followed for Policy Committee. However all attempts will be made to fast track this)</p> <p>30th September 2022</p>	<p>Richard Davies (Assistant Director of Capital and Estates) and Nicci Stephens (Environment & Sustainability Manager) to create group and overview writing of the policy.</p>
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Matter Arising 2: Governance Structure (Operation)		Impact
<p>It is important that an Executive lead is assigned with championing Waste related matters. The Waste Guidance Note does not include details of the nominated Executive.</p> <p>The Trust’s Waste Guidance Note document details that the National Estates Manager is the nominated General Waste and Recycling Manager, however operational responsibility for Clinical Waste across each site had not been formally assigned. Management advised that there is an Organisational Change Process currently underway and that this issue is to be addressed as part of this.</p>		<p>No accountability assigned for Clinical waste issues within the Trust.</p>
Recommendations		Priority
<p>An Executive lead should be identified for Waste related matters.</p> <p>The Trust should conclude the exercise to assign operational responsibility for Clinical waste management at each site.</p>		<p>High</p>
Agreed Management Action	Target Date	Responsible Officer
<p>Agreed. Whilst in practice there has always been Exec oversight to the various aspects of waste management, it is accepted that this isn’t formally documented. As above, the TFG work will identify a full management reporting structure and therefore executive leads, for which there is a potential for this continuing to be more than one. Clarity on this (and any split of responsibilities) will be required through along with the resulting reporting mechanisms.</p> <p>Formal correspondence relating to operations responsibility will be completed as part the TFG work and waste management policy.</p>	<p>On completion of written policy 30th September 2022</p>	<p>An output from the T&F group work and resulting waste management policy, to be overseen by Richard Davies (Assistant Director of Capital and Estates) and Louise Colson (Head of Infection Prevention & Control)</p>

Matter Arising 3: Governance Structure (Operation)		Impact
<p>The Waste Guidance Note document does not identify any Trust Committee with responsibility for waste management. Conformation was sought as to the forum at which Waste Management is routinely discussed, it was advised that Waste Management has not historically been an agenda item at any Trust committees/meeting groups.</p> <p>The National Estates Manager did advise that a 'Logistic Cell' has received information on waste as required, during the Covid pandemic, including waste contracts.</p>		Absence of Board-level commitment.
Recommendations		Priority
Both clinical and general waste compliance/ issues should be formally reported periodically within the confines of a set Committee/ Group.		High
Agreed Management Action	Target Date	Responsible Officer
<p>Once the TFG work is complete and executive lead(s) re-confirmed, this will then inform the committee/group receiving waste information. Routinely it is noted that reporting through to a Board Committee is likely to be on an exception only basis. Consideration will be given to ensure that Board members are sighted on more routine waste issues and compliance, at least annually.</p> <p>The National Waste Policy will also inform reporting timescales.</p>	<p>Process will be confirmed on completion of written policy</p> <p>30th September 2022</p>	<p>An output from the T&F group work and resulting waste management policy, to be overseen by Richard Davies (Assistant Director of Capital and Estates) and Louise Colson (Head of Infection Prevention & Control)</p>

Matter Arising 4: Training		Impact
<p>Waste management training is a module within Electronic Staff Records for all staff as well as being part of the standard induction process. For 2021/22, training compliance data was not available, management citing issues with the IT system which were beyond their control but were however escalated at the time.</p> <p>Furthermore, a formal training needs assessment had not been undertaken to determine more specific training needs and responsibilities for key roles. At the time of the audit fieldwork, there were no arrangements in place to deliver wider training to clinical and general staff, in respect of e.g. handling of clinical waste / recycling etc.</p>		Key staff are not appropriately trained.
Recommendations		Priority
<p>Training compliance data will be compiled and reported to an appropriate forum.</p> <p>A formal training needs assessment is required to determine the training requirements across the Trust.</p>		Medium
Agreed Management Action	Target Date	Responsible Officer
Agreed. A formal training needs assessment will be detailed under the TFG work and implemented by the National Training Department. Any remaining IT issues will be further escalated for resolution ASAP	30 th November 2022	An output from the T&F group work and resulting waste management policy, to be overseen by Richard Davies (Assistant Director of Capital and Estates) and Louise Colson (Head of Infection Prevention & Control)

Matter Arising 5: Clinical Waste Transfer Arrangements	Impact
<p>Clinical waste is collected from Trust sites by Health Courier Services (HCS) and transferred to two locations, these being Mamhilad in Pontypool and NWSSP Denbigh Stores. From there it is collected by the contractor for incineration. HCS were previously part of WAST but were disaggregated and are now part of NWSSP.</p> <p>Just prior to disaggregation HCS in a letter dated 2nd July 2015 agreed with Natural Resources Wales that they do not need to supply transfer notes when collecting clinical waste from WAST sites. Noting:</p> <p><i>“As we understand your operations waste produced on ambulances by healthcare activities is removed from the vehicle at ambulance stations when they return to base or drop off before another call at another base. This particular waste is then collected periodically by Health Courier Vehicles and taken to regional hubs in Pontypool and St Asaph. From here it is collected by external contractor for onward movement to treatment.”</i></p> <p>In the North the waste is now taken to Denbigh Stores, which is a facility operated by NWSSP. It is not clear therefore whether the present situation is in keeping with the spirit of the original ruling by NRW.</p> <p>We are advised that the Trust do not have a direct contract with the clinical waste contractor, the Trust accesses the contract via HCS.</p> <p>However, WAST are the producers of this clinical waste and as such have a legal responsibility. In specific guidance provided in WHTM 07-01 for the Welsh Ambulance Services Trust it notes:</p> <p><i>The ambulance service, as a producer of healthcare waste and specifically infectious waste, is required to comply with waste regulations including the Hazardous Waste Regulations and therefore needs to ensure that waste is segregated, described, classified and disposed of appropriately.</i></p> <p>WHTM 07-01 clarifies that:</p> <p><i>For waste that is disposed of through the ambulance station, the ambulance service should have a waste disposal contract with a registered and licensed waste contractor to safely collect, transport and dispose of its waste appropriately.</i></p>	<p>The Trust may be breaching the rules pertaining to Waste producers.</p>

<p>It is not clear that the Trust have complied with this in that HCS, who are no longer part of WAST and are not the producers of the Waste, have the contract with clinical waste contractor. In addition, WAST do not therefore have formal representation on the All-Wales Clinical Waste Consortium so it is not clear how they as the waste producer have a 'cradle-to-grave' responsibility for the control, management, transport and disposal of their waste.</p> <p>For example, waste producers should undertake a waste audit trail, at least every year. This to ensure that waste is being transported in accordance with the Carriage Regulations and disposed of at appropriately permitted facilities in accordance with duty-of-care requirements and local waste management procedures.</p> <p>In addition, if the waste contractor establish any non-conformance as regards waste submitted for treatment/incineration it is not clear how WAST as the producer would be held accountable.</p>		
Recommendations		Priority
<p>5.1 The Trust should review the arrangements in place for the transfer of clinical waste and seek to gain assurance that the current arrangements as detailed are in keeping with the requirements of WHTM-07-01.</p>		High
<p>5.2 The Trust should gain clarification from NRW regarding whether supply transfer notes are required for the revised arrangements for clinical waste.</p>		Medium
Agreed Management Action	Target Date	Responsible Officer

<p>5.1 – The WHTM 07-01 was amended from HTM 07-01 in 2013, this predates the separation of HCS from WAST. Under its current form WAST is not able to comply with this particular section of the document as WAST does not have a direct contract with the current clinical waste contractor. NWSSP FS, the documents authors, have been contacted regarding this point. The WHTM is due for review. However, those confirmed under the TFG as clinical waste lead will produce an annual hazardous waste transfer note for Denbigh Stores and Pontypool Ambulance Station for completion by HCS, therefore compliant with current hazardous waste legislation.</p> <p>5.2 HCS has already been contacted for clarity regarding NRW exemption – the NRW exemption belongs to HCS not WAST. Confirmation received that NRW exception is live and covers changes to location.</p>	<p>Amendment to WHTM – immediate (correspondence already send)</p> <p>Complete</p>	<p>Nicci Stephens (Environment & Sustainability Manager)</p>
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Matter Arising 6: Clinical Waste Transfer-Hospital Sites		Impact
<p>As part of operational practice Ambulances routinely decant clinical waste when visiting Hospitals to transfer patients. This is because they are limited in the amount of clinical waste that can be physically stored on the vehicles. However, whilst noting that this is good practice WHTM 07-01 goes on to note that:</p> <p><i>"Where the WAST drops its waste off at a hospital, this is classed as waste transfer. Therefore, duty of care applies and the WAST should ensure that the appropriate agreements are in place to enable it to transfer its waste to the hospital".</i></p> <p>WHTM-0701 goes onto note that whilst waste transfer notes are not required:</p> <p><i>"A duty of care transfer note is, however, required, although there are mechanisms to enable this to be done on an annual basis".</i></p> <p>No evidence was provided to demonstrate that WAST have obtained the transfer notes from the respective Health Boards.</p>	<p>Trust not in compliance with requirements of WHTM07-01.</p>	
Recommendations	Priority	
<p>WAST should contact the respective Health Boards on an annual basis to obtain a duty of care transfer note covering handover of clinical waste from Ambulances at Health Board sites, in keeping with the requirements as stipulated in WHTM 07-01.</p>	<p>High</p>	
Agreed Management Action	Target Date	Responsible Officer

<p>The WHTM 07-01 was amended from HTM 07-01 in 2013. HTM 07-01 is the English management of waste in healthcare technical note. On amending the HTM to the WHTM this section should have been replaced. As a commissioned service to the health boards clinical waste sits with the patient and therefore the health board. NWSSP FS, the documents authors, have been contacted regarding this point.</p> <p>However, to further add to the assurance of this, it is also now requested that the TFG will propose the production of an annual hazardous waste transfer note for each Health board, therefore compliant with current hazardous waste legislation. This will be included in the national waste management policy.</p>	<p>Immediate (correspondence already sent)</p> <p>On completion of written policy</p> <p>30th September 2022</p>	<p>Nicci Stephens (Environment & Sustainability Manager)</p> <p>An output from the T&F group work and resulting waste management policy, to be overseen by Richard Davies (Assistant Director of Capital and Estates), and Louise Colson (Head of Infection Prevention & Control)</p>
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Matter Arising 7: Independent reviews		Impact
<p>The Trust participates in several waste-related audits each year, including:</p> <ul style="list-style-type: none"> • ISO14001 Environmental System external audit; and • Annual internal Sustainability Management Review. <p>However, the Trust has not undertaken Clinical Waste Duty of Care audits (reviewing contractor practices) or Clinical Waste Pre-Acceptance audits (reviewing the segregation and handling of clinical waste on Trust premises).</p> <p>Management advised that these have not been conducted due to the historical arrangement that Health Courier Services (HCS) transport clinical waste from WAST premises to central locations and that the clinical waste contract rests with HCS.</p> <p>Compliance audits were previously undertaken in respect of general waste and recycling, however these were suspended during the Covid-19 response and have not been reinstated.</p> <p>Infection Prevention and Control Team audits were similarly affected by the Covid response with no audits undertaken during the pandemic. The Head of Infection Prevention and Control at The Trust advised that they are currently preparing a plan for this work to recommence</p>	<p>Independent assurance has not been obtained in respect of operations.</p>	
Recommendations		Priority
<p>The Trust will conduct its own Clinical Waste Duty of Care audits and Clinical Waste Pre-Acceptance audits.</p> <p>Infection Prevention and Control Team audits will be reinstated.</p> <p>General waste and recycling compliance audits will be reinstated when safe to do so.</p>	<p>High</p>	
Agreed Management Action	Target Date	Responsible Officer

<p>Audits will be resumed when safe to do so. This will be reviewed on a quarterly basis by the Clinical waste lead and Domestic Waste lead.</p> <p>Clinical waste audits will be completed as part of general IPC audits not as a specific waste stream audit.</p> <p>General waste audits are completed by Biffa as required under tendered contract. Further overseeing of this will be ensured.</p>	<p>30th September 2022 (assuming safe to do so)</p>	<p>Clinical waste: To be determined as part of the T&F group work, to be overseen by Richard Davies (Assistant Director of Capital and Estates) and Louise Colson (Head of Infection Prevention & Control)</p> <p>Domestic Waste: Estates (Biffa) overseen by Nicci Stephens (Environment & Sustainability Manager)</p>
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Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	<p>Substantial assurance</p>	<p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.</p>
	<p>Reasonable assurance</p>	<p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.</p>
	<p>Limited assurance</p>	<p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved.</p>
	<p>No assurance</p>	<p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.</p>
	<p>Assurance not applicable</p>	<p>Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.</p>

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
<p>High</p>	<p>Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.</p>	<p>Immediate*</p>
<p>Medium</p>	<p>Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.</p>	<p>Within one month*</p>
<p>Low</p>	<p>Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.</p>	<p>Within three months*</p>

* Unless a more appropriate timescale is identified/agreed at the assignment.



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Network & Information Systems (NIS) Directive

Final Internal Audit Report

May 2022

Welsh Ambulance Service NHS Trust



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Ymddiriedolaeth GIG
Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services
NHS Trust



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Executive sign-off:	Andy Haywood, Director of Digital
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Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors.

Acknowledgement

NHS Wales Audit and Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

Disclaimer notice - please note

This audit report has been prepared for internal use only. Audit and Assurance Services reports are prepared, in accordance with the agreed audit brief, and the Audit Charter as approved by the Audit & Assurance Committee.

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Executive Summary

Purpose

Review arrangements in place for the implementation of the NIS Directive in the Trust, including the Cyber Assessment Framework (CAF), improvement plan and overarching governance.


Overview

An appropriate process was in place to complete the CAF which accurately reflects the Trust’s cyber security position.

The matters requiring management attention include:

- No retention of supporting information provided to the Cyber Resilience Unit as part of the self-assessment process.
- Improvement action plan has not yet been developed.
- Insufficient oversight of cyber security matters by appropriate governance committees.

Report Classification

		Trend
	Reasonable Some matters require management attention in control design or compliance.	N/A
	Low to moderate impact on residual risk exposure until resolved.	First Review

Assurance summary¹

Assurance objectives	Assurance
1 CAF completion and maintenance of evidence	Reasonable
2 Accurate self-assessed position supported by evidence	Substantial
3 Improvement plan implementation	Reasonable
4 Governance	Reasonable

¹The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

Key Matters Arising	Assurance Objective	Control Design or Operation	Recommendation Priority
1 Supporting information retention	1	Operation	Medium
2 Improvement action plan	3	Design	Medium
3 Cyber security reporting	4	Operation	Medium

1. Introduction

- 1.1 Cyber security and resilience is the protection of computer systems and networks from the theft of or damage to their hardware, software, or electronic data, as well as from the disruption or misdirection of the services they provide.

A core piece of legislation relating to cyber security are the Network and Information Systems Regulations of 2018 (NIS Regulations), transposed into UK law in May 2018 from the EU Security of Networks & Information Systems (NIS) Directive, with the intention to raise levels of cyber security and resilience of key systems across the EU.

At the core of this piece of legislation is the aim to drive improvement in the protection of the network and information systems which are critical for the delivery of digital services and essential services in the UK. These regulations require bodies to have processes in place to protect themselves from attack, detect potential intrusions and react appropriately when intrusions occur.

Although cyber security is not a devolved matter, Welsh Government (WG) is the competent authority for the NIS in the case of essential health services in Wales.

Within NHS Wales, Digital Health and Care Wales (DHCW) takes a leading and coordinating role for the maintenance and improvement of cyber security on behalf of WG and is responsible for establishing the compliance framework for operators of essential services, which includes defining the scope of the regulations, reporting thresholds, and processes for reporting and dealing with cyber incidents. The Individual Trusts and Health Boards which fall within scope must adopt and comply with these arrangements.

- 1.2 The potential risks considered in the review are as follows:

- poor or non-existent stewardship in relation to cyber security;
- failure to comply with regulations; and
- loss of data or services and inappropriate access to information.

- 1.3 We note that the purpose of the audit is to provide assurance on the processes within the Welsh Ambulance Services NHS Trust ('the Trust') for assessing its current position in relation to cyber security and developing an improvement plan that will address the key identified weaknesses. This report does not assess the current state of cyber security within the organisation and this function is the responsibility of the Cyber Resilience Unit (CRU) within DHCW.

2. Detailed Audit Findings

Objective 1: a process exists for completion of the self-assessment and maintenance of appropriate evidence.

- 2.1 As part of the initial process, the Director of Digital, Head of Information and Communications Technology (ICT) and Senior ICT Security Specialist engaged with the CRU through a series of Microsoft Teams workshops. Following this, the Head of ICT gave a presentation to the Trust's Health Information Forum to appraise members of the NIS regulations and expected requirements.
- 2.2 Under direction from the CRU, one critical system was to be chosen to complete the Cyber Assessment Framework (CAF). As an Operator of Essential Services (OES), the Trust has a limited number of critical systems, therefore, undertaking the self-assessment against the Computer Aided Dispatch (CAD) system was unanimously decided upon.
- 2.3 We were informed by the Senior ICT Security Specialist that information to support each CAF objective was provided through discussions with the CRU via Microsoft Teams calls. The CRU did not specifically request evidence in the form of documentation as part of the assessment. However, we noted that records of the discussions and information provided have not been retained. As the self-assessment will be repeated annually, the lack of recorded information and clarifications sought from the CRU may hinder the timeliness and efficiency of future iterations. **See Matter Arising 1 at Appendix A.**

Conclusion:

- 2.4 Our review noted the work undertaken by the Trust's ICT team to prepare for and complete the self-assessment. However, records of discussions have not been appropriately retained for future iterations of the CAF. Consequently, we have concluded **Reasonable** assurance for this objective.

Objective 2: the self-assessed position is accurate and supported by evidence.

- 2.5 The CAF was completed by the Senior ICT Security Specialist with involvement from the Clinical Contact Centre Manager and Critical Systems Support Manager for technical input. Prior to submitting the CAF to the CRU, it was reviewed and signed-off by the Head of ICT.
- 2.6 Our review highlighted the completeness of the CAF with justifications included to support the scoring for each objective. We reviewed a sample of three objectives within the finalised CAF to ensure appropriate scoring:
 - B3.b Data in Transit;
 - B5.b Design for Resilience; and
 - D2.b Using incidents to drive improvements.

Whilst we noted above that evidence was not retained as part of the self-assessment process, documentation was readily available to demonstrate that the

corresponding Trust statements and scoring were an accurate reflection of current position.

Conclusion:

2.7 Our review of the CAF found it to be complete with supporting justifications provided for each objective. We consider the self-assessed position to be accurate and whilst evidence was not retained as part of the process, it was provided to us during our review. Consequently, we have concluded **Substantial** assurance for this objective.

Objective 3: an improvement plan is in place to improve the cyber security position within the organisation, is being implemented appropriately and monitored.

2.8 In January 2017, Stratia Consulting undertook an external cyber security assessment within the Trust. As part of this, a NIS Directive readiness assessment was undertaken, which identified that further work was required to ensure compliance with the NIS Regulations. A summary report and improvement plan were published following the assessment, which the Trust's ICT team have been working on to enact in preparation for the NIS self-assessment.

2.9 We note that whilst a formal improvement action plan is not yet in place due to the Trust awaiting the CAF outcome from the CRU, work to identify improvement objectives has commenced and a full action plan will be developed shortly. **See Matter Arising 2 at Appendix A.**

2.10 Whilst no critical remedial work was identified when undertaking the self-assessment, the ICT team have progressed some of the areas highlighted where improvements could be made. For example, the Trust held an extensive scenario-based exercise with the Operations Directorate and business continuity leads to review and improve business continuity plans for digital infrastructure failure.

Conclusion:

2.11 Initial progress has been made to identify gaps in compliance and to improve the Trust's current cyber security position. Whilst the ICT team are awaiting feedback from the CRU prior to developing a full improvement plan, Welsh Government guidance states that Operators of Essential Services will need to propose appropriate measures for improvement, and it will be for the CRU and Welsh Ministers to determine their sufficiency. Consequently, we have concluded **Reasonable** assurance for this objective.

Objective 4: there is monitoring and reporting of the progress of the improvement plan and gaps in compliance to an appropriate governance group.

2.12 As noted above, whilst a formal improvement plan has not yet been developed, our review has highlighted the work undertaken to date to strengthen compliance gaps identified within the self-assessment. In our recent *Digital Governance* audit report, it was noted that oversight of the Digital agenda would be clarified. The Information Governance Steering Group (IGSG) has been recommended as a

formal sub-committee of the Quality, Patient Experience and Safety Committee (QuEST). The terms of reference (TOR) for QuEST has recently been updated and approved, in which Information Governance and Information Security oversight has been strengthened. Paragraph 3.7(b) of the TOR specifically addresses adherence to the NIS Directive and states that the Committee will review progress of measures to improve information security.

- 2.13 Whilst there is now an identified governance route to report on cyber security matters, we noted that to date there has been limited narration. There are currently no metrics which track the status of cyber security and the efficiency in which issues or incidents are dealt with. We were informed that work to progress this matter is underway with intention to report monthly to the IT Senior Management Team and wider governance structure. **See Matter Arising 3 at Appendix A.**
- 2.14 A cyber security and data protection awareness session, led by the Trust's Director of Digital and joined by representatives from the National Cyber Security Centre, WG and the IT Director from Copeland Council, was held with the Trust Board in January 2022. Board members were apprised of the NIS Directive and given an overview of the effect of a ransomware attack experienced by Copeland Council to highlight the importance of cyber security. Board members also reviewed the risk of cyber-attacks and potential mitigations, and considered the elevation of the risk to the formal corporate register. We can confirm that the risk was rearticulated, approved by the Executive Management Team, and included within the Risk Management and Board Assurance Framework report presented to the Trust Board for approval on 24 March 2022.

Conclusion:

- 2.15 A cyber security and data protection awareness session was recently held with the Trust Board and progress has been made to emphasise its importance and its governance, including the escalation of the cyber security risk to the corporate risk register. Whilst there is now an identified governance route to report on cyber security matters, we noted that to date there has been limited updates provided to Board and its Committees. Consequently, we have concluded **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter Arising 1: Supporting information retention (Operation)		Impact
Our review highlighted that records of discussions and supporting information provided to the CRU have not been captured and maintained throughout the self-assessment process.		Potential risk of: <ul style="list-style-type: none"> poor or non-existent stewardship in relation to cyber security.
Recommendations		Priority
1.1 Management should ensure that for all future annual self-assessments, records of discussions and information provided to and from the CRU are captured.		Medium
Agreed Management Action	Target Date	Responsible Officer
1.1 The Trust will develop a central repository to hold supporting information in relation to the CAF and other associated IS standards along with associated procedures to ensure information is captured and its accuracy is maintained.	Dec 2022	Head of ICT


Matter Arising 2: Improvement plan (Design)		Impact
<p>Whilst we were informed that a formal improvement action plan is not yet in place due to the Trust awaiting the outcome of the CAF, Welsh Government guidance states that Operators of Essential Services will need to propose appropriate measures for improvement.</p>		<p>Potential risk of:</p> <ul style="list-style-type: none"> • poor or non-existent stewardship in relation to cyber security; and • failure to ensure that structures are developed to enable compliance with regulations.
Recommendations		Priority
<p>2.1 Management should ensure that an improvement action plan is developed promptly in order to avoid delays in implementation.</p>		<p>Medium</p>
Agreed Management Action	Target Date	Responsible Officer
<p>2.1 Since the audit the Senior ICT Security Specialist has produced a draft CAF improvement plan. This is under review along with associated planning activities such as identifying the budgetary requirements required.</p>	<p>Sep 2022</p>	<p>Head of ICT</p>

Matter Arising 3: Cyber security reporting (Operation)		Impact
3.1 Whilst there is an identified governance route to report on cyber security matters, we noted that to date there has been limited updates provided to Board and its Committees. There are currently no metrics which track the status of cyber security and the efficiency in which issues or incidents are dealt with.		Potential risk of: <ul style="list-style-type: none"> • poor or non-existent stewardship in relation to cyber security; and • failure to ensure that structures are developed to enable compliance with regulations.
Recommendations		Priority
3.1 Management should ensure that cyber security metrics are developed and reporting arrangements are strengthened to assure statutory committees and the Trust Board of improvements to information security arrangements and compliance with NIS Regulations.		Medium
Agreed Management Action	Target Date	Responsible Officer
3.1 The Senior ICT Security Specialist is currently developing a cyber dashboard to aid reporting on IS & Cyber issues. This will form part of the future structured reporting of IS via IGSG into the Trust QUEST committee (target meeting 09.02.2023).	Dec 2022	Head of ICT

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	Substantial assurance	Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.
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	Assurance not applicable	Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.

Prioritisation of Recommendations

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Priority level	Explanation	Management action
High	Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.	Immediate*
Medium	Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.	Within one month*
Low	Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.	Within three months*

* Unless a more appropriate timescale is identified/agreed at the assignment.



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Service Reconfiguration Final Internal Audit Report May 2022

Welsh Ambulance Services NHS Trust



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Auditors:	Simon Cookson, Director of Audit & Assurance Osian Lloyd, Deputy Head of Internal Audit Chris Scott, Internal Audit Manager
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Committee:	Audit Committee



Audit and Assurance Services conform with all Public Sector Internal Audit Standards as validated through the external quality assessment undertaken by the Institute of Internal Auditors

Acknowledgement

NHS Wales Audit & Assurance Services would like to acknowledge the time and co-operation given by management and staff during the course of this review.

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Executive Summary

Purpose


To provide assurance that the relationship between the Trust and Commissioner is effective in ensuring expected operational outcomes in its support of health board service changes.

Overview of findings

Key matters arising concerned:

- service specification document (not agreed until after the service commenced) extended at the first anniversary of the service delivery needs review and re-issue.
- limited evidenced inter-site transport service performance reporting within the Trust.
- absence of the new inter-site transport service from the Trust’s CCC auditing and spot-check process.
- incomplete collaborative project group meeting documentation.

Report Classification

		Trend
Reasonable	Some matters require management attention in control design or compliance.	Not previously audited
	Low to moderate impact on residual risk exposure until resolved.	

Assurance summary¹

Assurance objectives	Assurance
1 Engagement with collaborative fora	Substantial
2 Modelling service change	Reasonable
3 Plan to deliver new service	Reasonable
4 Assessing the new service	Limited
5 Sub Committee/ Board oversight	Reasonable

Key matters arising

	Assurance Objective	Control Design or Operation	Recommendation Priority
1	Renewing the service specification document	2 Operation	Medium
2	Inter-site transport journey operational performance review	4 Design	Medium
3	Inter-site transport journey auditing and spot-check scrutiny process	4 Design	Medium
4	Collaborative GUH Project meeting documentation	5 Operation	Medium

¹ The objectives and associated assurance ratings are not necessarily given equal weighting when formulating the overall audit opinion.

1. Introduction

- 1.1 Through its commissioning intentions, the Emergency Ambulance Service Committee (EASC) set an expectation that the Welsh Ambulance Services NHS Trust ('the Trust' or 'WAST') should support health board system transformation to be responsive to the new emerging demands and patterns of service delivery.
- 1.2 The Trust supports a range of regional developments and other health board initiatives through its Integrated Strategic Planning Group. The Group has oversight of health board operational and strategic service changes to comprehend and coordinate implications on the Trust and to design and implement responses to support these plans.
- 1.3 During 2020, the Trust supported the implementation of the South Wales Major Trauma network in September 2020 and the early opening of the Grange University Hospital (GUH) in November 2020.
- 1.4 Emerging from the latter, the GUH inter-site transport service, live since the opening of the hospital, was the first of its kind in Wales and is providing learning for a potential all Wales model. The Trust has delivered this service from its inception and supported EASC in an evaluation of the service completed in October 2021.
- 1.5 The overall objective of the audit was to provide an assurance that the relationship between the Trust and Commissioner is effective in ensuring expected operational outcomes. The audit focussed on the sharing of information and engagement around the GUH inter-site transport service, an example of service change that included transport plans across both the Emergency Medical Service (EMS) and Non-Emergency Patient Transport Service (NEPTS).
- 1.6 The key risks considered in this review included:
 - a) patient harm as a result of insufficient planning arrangements;
 - b) lack of resource availability due to insufficient planning, resulting in increased financial costs; and
 - c) lack of awareness of revised operational arrangements and reputational damage as a result of services not operating as intended.
- 1.7 The impact of the early opening of the Grange University Hospital on the service reconfiguration example examined in the audit (GUH inter-site transport service) was taken into consideration in our assessment of the appropriateness of the arrangements in place.

2. Detailed Audit Findings

Audit objective 1: The Trust engaged with health boards in collaborative forums where service redesign was planned and developed.

- 2.1 We sought to establish that the Trust is responsive to the directions of commissioners and the changing needs of the health boards in respect of wider service changes arising from shifts in health care priorities and service delivery reconfiguration.
- 2.2 We noted the Trust engages with health boards and the Emergency Ambulance Services Committee (EASC) as well as community and patient groups (although the latter did not form part of the scope of this review) in a variety of consultative and collaborative fora, through which joint initiatives are identified, developed and delivered.
- 2.3 WAST and EASC communicate and work collaboratively with support from the National Collaborative Commissioning Unit (NCCU), which has the following vision: *'Leading quality assurance and improvement for NHS Wales through collaborative commissioning'*. The NCCU deliver work programmes on behalf of EASC, working collaboratively with clinicians, organisations and Welsh Government. The EASC annual plan for 2021/22 centres on transformational work programmes, which includes national transfer and discharge services.
- 2.4 Chaired by the Chief Ambulance Services Commissioner (CASC), the EASC Management Group (EASC MG) and NEPTS Delivery and Assurance Group (DAG) are the collaborative forums of EASC, health boards and WAST in which the joint initiatives emerge, are captured and managed (this area was included in the scope of our 2021/22 report titled 'Collaboration'). Meetings of these groups are nominally monthly and each submit highlight reports to the EASC committee meetings that take place every 2 months.
- 2.5 WAST monitors the service change programmes that they are involved with via the Integrated Strategic Planning Group (previously the Senior Planning Forum) to strengthen arrangements within the Trust. With the aid of a tracking tool, a high-level management record which we have not tested in detail in this audit, progress is reported to the Service Transformation Board (STB) which monitors the progress of the Trust's Integrated Medium Term Plan (IMTP) deliverables and regularly reports on their status to the Board.
- 2.6 We noted health boards are also being encouraged by WAST to provide more notice of service changes to enable them to better respond to these (fora set up with health boards, focussing on ABUHB in this review, to deliver service change initiatives are examined under subsequent audit objectives).
- 2.7 In addition to being captured in the EASC Annual Plan, we noted that service change and other joint initiatives are captured in the IMTPs of the respective organisations which are developed and shared in a collaborative manner.

Conclusion:

2.8 The Trust engages with health boards and EASC in a variety of collaborative fora through which joint initiatives are identified, developed and delivered. There are implications on WAST of short term reactive service changes by their partners and the Trust has taken steps to encourage health boards and others to recognise this and give early notice of change. We have noted the role of the Integrated Strategic Planning Group to strengthen arrangements to monitor service change programmes and consequently have provided **Substantial** assurance for this objective.

Audit objective 2: The Trust modelled new patient flows and assessed the impact of these on the service.

2.9 Service changes within NHS Wales frequently affect patient flows, creating impacts on WAST to which they must respond. There are a number of such service reconfiguration initiatives underway at any given time and we noted five in progress in the South-East region at the time of the audit.

2.10 For the purposes of the evaluation of the WAST response to service changes, the audit focussed on the inter-site transport requirements for the Grange University Hospital. This involved WAST providing both emergency and non-emergency transport for new patient flows between the acute GUH and its neighbouring re-designated lower acuity 'enhanced local general' and community hospitals. The service was commissioned by ABUHB and began in November 2020 on the earlier than planned opening of the GUH which posed a significant challenge (original opening date March 2021, early opening date of November 2020 signalled in WAST project documents and at the ABUHB Board meeting in June 2020).

2.11 We sought to establish that there was effective modelling of a range of possible service delivery options, that there had been appropriate scrutiny and challenge of the models put forward, and that an evaluation process had been undertaken that compared the impacts on current WAST services in South East Wales of the different configuration options.

2.12 Following detailed work by ABUHB clinicians using historical case data to determine the resources needed and costs of delivery, examination and modelling of four service configuration scenarios was carried out by an external consultant using estimates of volumes, mix of acuity, destinations, journey times, crews etc. All four scenarios evaluated involved the establishment of an ABUHB manned Flow Centre co-located with the WAST Clinical Contact Centre (CCC) at Vantage Point House (VPH) near Cwmbran, using a Transfer Triage Tool (software tool) to assess caller's needs. The scenarios were:

Scenario 1:	Fully ring-fenced tier of additional Emergency Ambulances, staffed by Paramedics
Scenario 2:	Absorb all additional workload within the existing EMS service (Optima preferred model)

Scenario 3:	Four-tiered pool of ring fenced resources. (ABUHB Hybrid Model)
Scenario 4:	Some activity undertaken by EMS, and remaining activity delivered by a two-tier pool of vehicles. (WAST Proposed Model)

- 2.13 Detailed evaluation of the scenarios was carried out by the WAST project team who then proposed and presented their recommended service model to ABUHB (scenario 4) who would be commissioning it (although we noted that the recommendation was not the option preferred by Optima who had conducted the scenario modelling).
- 2.14 We noted testing of the Transfer Triage Tool (TTT) and Flow Centre processes (both common to all four scenarios) took place prior to go-live where the use of these tools and processes were piloted. We saw action logs which captured and addressed the issues that arose, and we noted a number of amendments were made to systems and processes as a result of the pilot runs that were conducted.
- 2.15 We noted oversight of the governance of the project by decision making groups of WAST (including GUH Project Board, Senior Operations Team and Executive Management Team) and the ABUHB Board was evidenced in a decision log which recorded choices, options and judgements made across the project timeline. We noted the regular schedules of meetings were in some cases interrupted by the pandemic in 2020 but nevertheless, subsequent meeting records of key oversight groups (including EASC MG, WAST STB and the collaborative GUH Transport Group (NCCU, ABUHB, WAST) and its ABUHB Flow Centre groups) make later reference to the inter-hospital transport requirements for the GUH project and the choice of the model recommended to deliver the service. The GUH project group decision log captures regular involvement, engagement and approval from the Trust's Executive Management Team, which also received project highlight reports, often through e-mail confirmation from the Trust's Director of Strategy, Planning and Performance.
- 2.16 Formal acceptance by ABUHB of the service model that had been recommended was evidenced in a letter from the ABUHB CEO to the WAST CEO in July 2020 and in April 2021 the Chief Ambulance Service Commissioner (CASC) was informed of the commissioning and commencement of the service. The Heads of terms agreement was signed by ABUHB, WAST and EASC prior to the brought forward go live date. We noted recognition that it had taken some time to finalise and agree terms of the full commissioning agreement resulting from the early opening of the Grange and that the service specification set for the first 12 months of service delivery had expired in November 2021. We were advised this was extended for a period of 6 months (although we have not seen evidence of this) and is now in the process of review by the collaborative GUH inter-hospital transfer service forum, on conclusion of which it will be agreed and re-issued (see **Matter arising 1**).

Conclusion:

2.17 The project developed and tested a range of models for delivery of the service and selected a preferred option for implementation. We noted however, the service specification that formalises the commissioned service, and which had taken some time to finalise, is now due for review and re-issue and consequently have provided **Reasonable** assurance for this objective.

Audit objective 3: The Trust established an operational plan for the delivery of the proposed transfer and discharge arrangements.

2.18 We sought to establish how WAST planned the integration of the new transport service into its existing ambulance transport framework.

2.19 Project development and implementation was driven by a task level plan managed by the project team in a GANNT style format (although we did not examine these plans at the workstream level) and we saw that outstanding tasks for the delivery of the proposed new service were monitored in the project highlight reports as the go-live date approached.

2.20 We noted that the plan for the implementation and delivery of the inter-site transport service was being led by the collaborative GUH Transport Group in which staff of ABUHB, WAST and NCCU (chairing) were involved. Although we examined only example material rather than testing a formal audit sample of the documentation of the group, topics we noted being covered by the latter in their action plan were wide ranging but included arranging their co-location at Vantage Point House (VPH), staff consultation for operational site management at sites and development of standard Operating Procedure (SOP) documents.

2.21 We sought to establish the means by which WAST had incorporated the new GUH inter-site transport service into its operational planning and delivery framework.

2.22 For delivery of the inter-site transport service, dedicated resources were provided at levels determined through the service modelling work and confirmed in the commissioning agreement between WAST and ABUHB.

2.23 We noted there is a WAST SOP in place which describes the deployment of WAST commissioned resources to planned hospital transfers (inbound and outbound) between the GUH and enhanced Local General Hospital (eLGH) sites in ABUHB. Within this SOP, all planned transfers are directed through the ABUHB Flow Centre and any patients requiring Ambulance transport are booked via the Flow Desk based at VPH adjacent to the WAST CCC. The SOP has been approved by the CCC Technical Manager and Area Manager for EMS CCC and we were advised it also went through both the Project Team and the Senior Operations Team meetings for approval prior to go live. The SOP is to be included in the scope of a post-evaluation development group where it will be reviewed and amended if necessary. We also received separate ABUHB SOPs for step down patients (adults) and step up patients (adults) respectively, but noted that the copies provided were in draft.

Conclusion:

2.24 The Trust programmed additional dedicated ambulance and people resources into its operational plan to support the delivery of the new service. We have provided **Reasonable** assurance for this objective.

Audit objective 4: The Trust conducted assessment of the running of the reconfigured service, identifying and addressing any issues that emerged.

2.25 We sought to establish the means by which WAST had assessed the effectiveness of the transport model it had chosen and implemented and to what extent they had identified and addressed any issues that emerged from that assessment. The commissioned service was designed to facilitate 72 transfers (33 step up transfers & 39 step down transfers) per day, utilising both dedicated transfer resources and accessing a pool of emergency service ambulances.

2.26 As part of the service's commissioning arrangements, it was agreed an evaluation would be completed following the first 6 months of service delivery and we noted post implementation assessments were undertaken by both EASC and WAST in the middle of 2021.

2.27 We noted the EASC evaluation findings included the following matters:

- *the model in use matched that which had been recommended by WAST to ABUHB, albeit adapted to respond to the challenges of the Covid19 pandemic and the requirements of the population it served;*
- *the overall demand for the service was significantly less than expected because of these adaptations;*
- *the level of transfer ambulance resources were appropriate given that the service modelling was developed using higher demand profiles;*
- *performance measures had not been achieved due to the challenges experienced by ABUHB and WAST in responding to the requirements of the population during the Covid19 pandemic;*
- *the Transfer Triage Tool was supported as an effective and safe tool for the clinical triaging of patients requiring inter hospital transfer;*
- *a safe and high quality patient service had been delivered to date with minimal, if any, harm to patients reported;*
- *initial mechanical and build quality issues with the new transfer ambulances had been overcome;*
- *challenges remained with booking and communications systems which required improvements in order to make better use of the available resource, improve quality for patients and the performance of the service overall.*

The evaluation report, which was submitted to the WAST Finance and Performance committee in September 2021, went on to recommend a series of actions to address the issues that had been identified. These recommendations were handed over to the WAST Ambulance Care Programme Board.

2.28 In the Autumn of 2021, the WAST evaluation was set out in a formal closure report from the WAST GUH Project Board. This report detailed what had been

achieved by the new service in the first six months of its running. Overall, it concluded that a safe and good quality patient service had been delivered with minimal, if any harm to patients reported and this had been running in a steady operational state, but the following key issues were raised:

- flow, patterns of demand (high variability) and activity types impacting on performance;
- opportunities within WAST for further system improvements; and
- losing hours through handover delays, issues with discharge lounge.

2.29 The report also included sections on benefits achieved to date, the achievement of planned objectives and products / outputs, follow on actions (including those set out in EASC's independent evaluation) and lessons learnt. It set out the risks remaining open or pending closure without final project board closure decision and the recommended action in order to close down the risks and the project. We saw evidence that these matters had been handed over to operational business as usual, via the WAST Ambulance Care Programme Board as noted above, who were tasked with realising the benefits from the delivery of the project. We saw an action plan was put in place to address the recommendations, although we noted these remained open at the time of this audit.

2.30 The inter-site transport service is separately commissioned and therefore subject to external scrutiny and monitoring and this is delivered through a collaborative Tier group meeting structure involving EASC (chair), WAST and ABUHB who monitor service delivery against the service levels set in the commissioning agreement between ABUHB and WAST. The structure has 2 levels comprising an oversight level (Tier 2) and an operational level (Tier 3). We noted Tier group 2 meetings receive reports of ABUHB Flow Centre ambulance transport activity which cover a range of ambulance journey related metrics across EMS, NEPTS and EMRTS functions, with a set of outputs specifically covering the GUH inter-site transport activity.

2.31 We also identified volumes and values of these journeys, albeit at summary level, and within a very extensive information pack, in the Senior Operations Team weekly performance, demand and capacity slide decks. Through this they are included in the scope of the review of this oversight group but this we noted was restricted to the lost hours metric only. We were advised that analysis of transport metrics, including step up / step down volumes, one and four hour response statistics, that is seen by the Tier 2 group is operationally reviewed at the General Managers Performance meeting within NEPTS every week, although we note that these meetings have agendas but are not minuted so we were unable to review evidence of matters discussed (see **Matter Arising 2**). We were also unable to establish where, if anywhere, this same ambulance transport activity is included in the regular quality assurance auditing conducted by the WAST CCC (see **Matter Arising 3**). We understand that the inter-site transport activity is included within the scope of the Ambulance Care indicator in the MIQPR, although we did not see the inter-site transport being specifically referred to in recent indicator tables or accompanying narrative.

- 2.32 The GUH inter-site transport project was an element of the broader IMTP objective 'Engage with Aneurin Bevan UHB (ABUHB) on the implementation of the Clinical Futures Strategy & opening of The Grange University Hospital' included in the WAST IMTP operational delivery plan 2020-21 and as such its delivery status was regularly reported to the WAST Strategic Transformation Board. We noted that the IMTP Delivery Programme's Q2 Assurance Report to the Board in November 2021 recorded in the update of the Ambulance Care Transformation Programme that the evaluation of the Grange Transfer and Discharge service had been completed and that all outstanding actions and risks had been handed over to Operations from the Project (although we did not conduct any testing to confirm these were subsequently incorporated into business as usual activities).

Conclusion:

- 2.33 Assessments of the new service in its first 6 months of operation were generally supportive of its running, however we noted a low level of performance metrics of the inter-site ambulance transport activity in regular WAST operational performance management reports. We were also unable to establish where this same activity is included in the regular quality assurance auditing conducted by the WAST CCC. Consequently, we have given a **Limited** assurance rating for this objective.

Audit objective 5: The Trust reported to Trust Board and Commissioners the progress and outcomes of the reconfigured service and collaborated in the building of an all-Wales model for roll-out.

- 2.34 We sought to evidence that appropriate reporting to oversight bodies of the inter-site transport service progress and outcomes was taking place.
- 2.35 The GUH inter-site transfer project reported to a range of oversight groups (STB, EASC MG, EMS Demand & Capacity group, GUH Transport group and the Senior Clinical Forum) and we reviewed records of the STB and EASC MG meetings and the GUH Transport group to confirm oversight had been active during the project phase.
- 2.36 The Trust Board receives a regular report of IMTP deliverable status updates from the STB. As mentioned above under the previous audit objective, this project is an element of the IMTP deliverable 'Engage with ABUHB on the implementation of the Clinical Futures Strategy & opening of The Grange University Hospital' and we noted this was given a green RAG status in the August, September, October and November 2020 STB updates, the latter shortly before the inter-site transport service commenced. As regards the partners, ABUHB and NCCU were in collaboration with the Trust in the development of the project through their involvement in regular Commissioning meetings and collaborative groups.
- 2.37 We noted updates on the progress of the inter-site transfer project in the meeting minutes of the EASC MG (comprising NCCU, WAST, and all health boards) and the GUH Transport group (NCCU, WAST and ABUHB). We saw evidence of oversight activity in meetings agendas, papers, highlight reports, minutes and action logs, although we tested only example documentation of the latter rather than a formal

audit sample. From this, we understand there was a period when some of the joint meetings with NCCU and ABUHB had not been minuted, noteworthy given the significance of this service change and the intention to replicate across Wales. (see **Matter Arising 4**).

- 2.38 We were provided with materials to demonstrate that the WAST GUH Project Team conducted regular meetings, weekly before the go-live date and fortnightly after, and examined example meeting agendas, minutes, actions log, highlight reports and the project risk register.
- 2.39 EASC Commissioning intentions include an ambition that implementation of inter-site transport models of this kind be used to inform like developments in other health board areas through the development of an all-Wales model and we sought to establish what progress had been made with the latter.
- 2.40 We noted the WAST project closure report commented on the longer-term strategic direction of the trust in developing an all-Wales model that could be deployed to support other health boards across the country. This report includes an action to work with ABUHB on the future model and clinical profile required in conjunction with NCCU and the All Wales Transfer and Discharge service, which aligns with the related component of the EASC commissioning intention CI6: Wider Health System.
- 2.41 We were advised that the post-implementation evaluation report of the GUH inter-site transport activity has been shared with Hywel Dda University Health Board who are exploring a similar service change. We note lessons learned in the design, development and deployment of the ABUHB inter-site service may be of value to the broader EASC led initiative which is targeting completion of a business case by the end of Q4 2022-2023 in support of an all-Wales proposal.

Conclusion:

- 2.42 Trust collaboration with and reporting to its commissioners in the development and implementation of the new service was evident, although we have raised a finding drawing attention to gaps in the collaborative oversight group's meeting records. Whilst the experience gained in the development of this inter-site transport service may be of value in the design of an all-Wales model, further work will be required to determine whether the model adopted to support the Grange and its eLGH partners will suit other deployments and consequently have provided **Reasonable** assurance for this objective.

Appendix A: Management Action Plan

Matter arising 1: Renewing the service specification document (Operation)

Impact

We noted recognition that it had taken some time to finalise and agree the full commissioning agreement / service specification that was drawn up to cover the first 12 months running of the inter-site transport service. The original agreement expired in November 2021 and we were informed that it was extended for 6 months, which was approaching expiry at the time of the audit. A renewed and potentially revised specification (the project closure report noted that there had been problems once in operation over the division of responsibility for managing the service) has not yet been put in place to replace it (but is being progressed by the collaborative GUH inter-hospital transfer service forum). This has significance beyond the two parties to this service activity as the SLA may be drawn on to inform an all-Wales model for similar future service reconfigurations.

Potential risk that the service model going forward does not reflect and adopt lessons learned during the first year of running and that as a result maximum service efficiency is not attained.

Recommendations

Priority

- 1.1 We recommend that the service specification is finalised and reissued for the period beginning June 2022, reflecting any amendments to the model that post-implementation service reviews have indicated. This is particularly significant because of the contribution this project may make to an upcoming all-Wales model to cover similar service reconfigurations. Future service change SLAs must be signed before the renew date.

Medium

Management response

Target Date

Responsible Officer

- 1.1 The timescale is dependent on commissioners agreeing the longer term commissioning agreement. Meetings with commissioners (ABUHB and NCCU leading) have commenced to take forward the recommendations of the GUH Evaluation and this should include the agreement on the next commissioning agreement. However this may need to be backdated.

30 September 2022

Mark Harris, Assistant Director of Operations NEPTS / Deborah Kingsbury, Senior Planning and Performance Business Partner

Matter arising 2: Inter-site transport journey operational performance review (Design)**Impact**

Whilst the GUH inter-site transport journeys are included in the scope of the regular performance scrutiny work conducted by the WAST Senior Operations Team, we noted this is limited to the lost hours metric. We noted the analysis of transport metrics (step up / step down volumes, one and four hour response statistics) that is seen by the collaborative Tier 2 group is operationally reviewed at the General Managers Performance meeting within NEPTS every week. However, although these meetings have agendas we understand they are not minuted so we were unable to review evidence of the matters discussed.

Potential risk that performance of the inter-site transport activity does not receive sufficient management oversight.

Recommendation**Priority**

- 2.1 We recommend that the weekly NEPTS General Managers Performance meetings are minuted and that consideration is given for the Senior Operations Team to delegate responsibility to review and scrutinise the transport activity further within the Trust, given the intention to expand the model across Wales.

Medium

Management response**Target Date****Responsible Officer**

- 2.1 This is agreed. NEPTS General Manager responsible for the Grange to ensure performance reporting mechanisms in place internally ahead of external tier 1 and tier 2 meetings, and agreement to be sought from SOT on delegation of responsibility to review performance of this service, with agreed routes for escalation of risks and issues arising from review and scrutiny.

30 June 2022

Gaurav Shinde, Head of Transformation

Matter arising 3: Inter-site transport journey auditing and spot-check scrutiny process (Design)**Impact**

Whilst an auditing activity of incident handling (assessment, allocation, despatch etc.) is conducted by a dedicated team within the WAST CCC, we noted that the GUH inter-site transport journeys fall outside of this and are therefore not subjected to this quality review and scrutiny process.

Potential risk that the inter-site transport activity does not receive quality and scrutiny review.

Recommendation**Priority**

- 3.1 We recommend that the inter-site transport service activity is incorporated into the regular case auditing activity operated by the CCC to ensure it is subjected to this quality review and scrutiny process.

Medium

Management response**Target Date****Responsible Officer**

- 3.1 WAST CCC Management Team to work with NEPTS control to review how this can be incorporated into auditing activity, in line with other internal audit recommendations.

30 September 2022

Kate Blackmore, Head of Service, EMS Coordination /
Gaurav Shinde, Head of Transformation

Matter arising 4: Collaborative GUH Project meeting documentation (Operation)**Impact**

We noted updates on the progress of the inter-site transfer project in the meeting minutes of the collaborative GUH Transport group (NCCU, WAST and ABUHB). Whilst we saw evidence of activity in meetings agendas, papers, highlight reports, minutes and action logs, although we examined only example documentation of the latter rather than a formal audit sample, and understand there was a period when some of these joint meetings had not been minuted.

Potential risk that project progresses without heed to events or decisions because of a lack of recording of these.

Recommendation**Priority**

- 4.1 We recommend that full and regular project meeting materials are maintained of collaborative as well as internal project meetings throughout the duration of projects of this nature, to ensure complete records of project decisions and actions. This should also assist in informing the transfer and discharge service model across Wales.

Medium

Management response**Target Date****Responsible Officer**

- 4.1 The external management of meetings is outside WAST Control, however we will request that a minimum set of project records are kept in joint projects with Health Boards and/or NCCU. There is already in place a minimum set of documentation requirements for programmes and projects in WAST.

Complete

Alex Crawford, Assistant Director of Planning and Transformation

Appendix B: Assurance opinion and action plan risk rating

Audit Assurance Ratings

We define the following levels of assurance that governance, risk management and internal control within the area under review are suitable designed and applied effectively:

	<p>Substantial assurance</p>	<p>Few matters require attention and are compliance or advisory in nature. Low impact on residual risk exposure.</p>
	<p>Reasonable assurance</p>	<p>Some matters require management attention in control design or compliance. Low to moderate impact on residual risk exposure until resolved.</p>
	<p>Limited assurance</p>	<p>More significant matters require management attention. Moderate impact on residual risk exposure until resolved.</p>
	<p>No assurance</p>	<p>Action is required to address the whole control framework in this area. High impact on residual risk exposure until resolved.</p>
	<p>Assurance not applicable</p>	<p>Given to reviews and support provided to management which form part of the internal audit plan, to which the assurance definitions are not appropriate. These reviews are still relevant to the evidence base upon which the overall opinion is formed.</p>

Prioritisation of Recommendations

We categorise our recommendations according to their level of priority as follows:

Priority level	Explanation	Management action
<p>High</p>	<p>Poor system design OR widespread non-compliance. Significant risk to achievement of a system objective OR evidence present of material loss, error or misstatement.</p>	<p>Immediate*</p>
<p>Medium</p>	<p>Minor weakness in system design OR limited non-compliance. Some risk to achievement of a system objective.</p>	<p>Within one month*</p>
<p>Low</p>	<p>Potential to enhance system design to improve efficiency or effectiveness of controls. Generally issues of good practice for management consideration.</p>	<p>Within three months*</p>

* Unless a more appropriate timescale is identified/agreed at the assignment.



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Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	13
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

Business Continuity Assessment June 2022

MEETING	Finance and Performance Committee
DATE	18 th July 2022
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Joanne Hodson, Locality Manager (EPRR)
CONTACT	Joanne Hodson. Joanne.hodson@wales.nhs.uk

EXECUTIVE SUMMARY

1. Business continuity is the ability of an organisation to continue the delivery of services to a pre-agreed level following disruption. The Trust are commissioned to provide certain services, but it is also a requirement of the Civil Contingencies Act (Cabinet Office, 2004) and the Welsh Government 'Emergency Planning Core Guidance' (2015) that the Trust have the ability to continue to deliver these core services and activities.
2. The Trust have a Business Continuity Management System (BCMS) which has been audited twice and improvements made but it is an iterative process which should grow and adapt with the organisation.
3. A previous audit recommended a Business Continuity (BC) report should go to Audit Committee annually. The January 2022 report was delayed facilitating the inclusion of learning from the EU Exit and COVID. This assessment is in place of an annual report and takes stock of our BC preparedness. The report will now be presented through Finance and Performance Committee and makes recommendations for future progress.

Recommendations for the future of Business Continuity within WAST

- a) WAST should strive to improve the recognition at all levels of the organisation that BC is an essential, ever present, underpinning activity that supports the delivery of all Trust services and is a legislative requirement.
- b) Committee are therefore asked to receive this assessment of our preparedness and note the following actions which are taking place:
 - **NOTE** the review of the Trust Business Continuity Management System to assist in identifying and mitigating risks through a structured process and putting robust plans in place

- **NOTE** the review of the business case to support the implementation of Business Continuity software (initially costed at £100,000 revenue cost for a 5 year package or £22k per annum)
- **NOTE** the system mapping to identify priority digital infrastructure and systems and strengthening cross-department working to highlight interdependencies.

NOTE the aspiration to create a culture of business continuity considerations in any system, process, fleet or estate design and delivery through the project management

KEY ISSUES/IMPLICATIONS

The result of the 2014 audit of WAST business continuity readiness was 'limited assurance' which was increased to 'reasonable assurance' in 2017 and 2018. Since 2018, all the recommendations have been met or partially met.

Over the past 2 years, BC plans including Severe Weather, Pandemic, REAP, DMP (CSP) and EU Exit have been written, reviewed and updated, and tested in both incidents and exercises. The process of review and implementation of risk-specific plans is embedded; risk assessment, Business Impact Analysis (BIA), interdepartmental dependencies, training, and provision of plan awareness tend to be applied to systems and processes that are already in place rather than growing with their design and implementation.

Although all departments have BIA in place, threads around interdependencies are not always apparent so are not fully understood or planned for. Like many organisations, WAST does not have an overarching BIA to illustrate what it delivers and how, the critical activities shown in the existing BIAs are often the perception of the department and their role rather than driven from top down or linked with the organisational objectives. Departments also have Business Continuity Plans (BCPs) but these could be improved to give more structure to the options available when responding to an issue. BIAs should give rise to recognition of risks, the risks recorded and mitigated in line with the Trust policies, however this is not currently embedded as normal practice.

Training of staff to complete a BIA has previously been delivered but staff turnover and currency suggests more is required. The EPRR Officers who support the BC leads have completed the Certificate in Business Continuity from the Business Continuity Institute and will use this knowledge to design training and exercises. Exercises have taken place to test plans, notably Pandemic Flu (now Pandemic) plan at the start of COVID, Winter/Seasonal planning, and Exercise Fuchsia Flamingo which looked at staff abstraction based on pandemic planning assumptions. A schedule of testing was in place prior to COVID, this needs to be reviewed.

Cyber attacks are recognised in the National Security and Risk Assessment (2019) and the risks mitigated within WAST by Digital Security processes. It was identified through exercises such as Draig Goch (facilitated by Welsh Government and attended by WAST) and recognition of wider learning from an attack on HSE in Ireland that it would be good practice to identify our key systems and infrastructure and gain assurance around fallback options and management. Scoping started in September 2021 leading to Exercise Joshua in March 2022. This exercise gave structure to the proposed Critical ICT Disruption plan which will be tested in Exercise Joshua 2 in July 2022.

REPORT APPENDICES	
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Appendix 1 – SBAR

REPORT CHECKLIST			
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Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	Y	Financial Implications	Y
Environmental/Sustainability	Y	Legal Implications	Y
Estate	Y	Patient Safety/Safeguarding	Y
Ethical Matters	Y	Risks (Inc. Reputational)	Y
Health Improvement	Y	Socio Economic Duty	Y
Health and Safety	Y	TU Partner Consultation	Y



No. Appendices	
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Business Continuity Assessment June 2022

MEETING	Executive Management Team
DATE	23 rd June 2022
SPONSOR	Judith Bryce, Assistant Director of Operations
AUTHOR	Joanne Hodson, Locality Manager (EPRR)
CONTACT DETAILS	joanne.hodson@wales.nhs.uk

CORPORATE OBJECTIVE	
CORPORATE RISK (Ref if appropriate)	
QUALITY THEME	
HEALTH & CARE STANDARD	Safe Care Standard 2.1 Governance Leadership and Accountability

REPORT PURPOSE	Approval
CLOSED MATTER REASON	N/A

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
Senior Leadership Team	30 th June 2022	Noting
Executive Management Team	6 th July 2022	Noting
Finance and Performance Committee	18 th July 2022	Approval

1. Introduction

- 1.1 The Trust meets business continuity challenges on a regular basis, from poor weather, IT interruptions and system loss, events during seasonal pressures, or even pandemics.
- 1.2 The EU Exit brought additional concerns regarding staff levels, procurement and suppliers' ability to provide sufficient stock of key items, and potential delays at Ports causing wide-area traffic disruption.
- 1.3 COVID-19 provided the largest and longest business continuity issue we have faced yet, requiring
 - rapid processing of legislation and guidance at short notice,
 - procurement and management of specific PPE, and the testing, training and distribution for staff to use it,
 - information sharing with the public, staff and partners
 - provision of clear guidance to staff who were concerned for their own health and that of their family, friends, colleagues, and patients
 - understanding of staff welfare needs, particularly in the light of shielding, potential long COVID and the tragic deaths in service
- 1.4 Risks and issues do not occur in isolation. The Trust was able to meet these concurrent issues due to strong decisive leadership, a structured management process, the staff working together toward common goals. This required risk assessments, planning, response and creative thinking such as splitting our response phase into a response and monitor phase to help manage the waves of the Pandemic.
- 1.5 This report will look back on previous audits, show where the Trust currently sits in terms of BCMS and provides recommendations to improve the processes and mature the system.

2. Business Continuity Management Systems (BCMS)

- 2.1 Business continuity is the ability of an organisation to continue the delivery of services to a pre-agreed level during disruption, and then recover. To achieve this, potential outcomes (risks) are identified and mitigated, and plans put in place to manage them should they become realised (issues). A mature Business Continuity Management System (BCMS) provides numerous advantages to the organisation:
 - Increases an organisation's ability to continue during a period of disruption
 - Processes help give staff a better understanding of the organisation
 - Provides an environment where improvement can occur

2.2 At a Strategic, organisational level, risks are generally grouped as:

- Political
- Economic
- Socio-cultural
- Technological
- Legal
- Environmental
- Reputational

2.3 At a delivery level we look at disruption to:

- People/Staffing
- Premises/Estates
- Technology
- Fleet
- Utilities
- Information
- Supplies

2.4 To identify and understand the risks, a business impact analysis (BIA) is undertaken to identify what the business delivers, and detail the processes associated with the 'critical activities' required. Risks identified as part of the BIA should be recorded as per Trust policy including mitigation. Mitigation takes the form of designing systems to be resilient, and writing, sharing and testing of Business Continuity Plans (BCP) to be used should a disruption occur.

2.5 WAST, as a Category 1 responder under the Civil Contingencies Act (2004) and Regulations (2005), have a duty to ensure we have business continuity plans in place. There is no requirement for the Trust to be accredited to International Standard ISO22301 but we work to achieve its framework.

2.6 Welsh Government emergency planning documentation¹ give the Chief Executive officer the responsibility of ensuring plans are in place and we comply with the CCA (2004). NHS England² require their organisations to self-assess against a set of Core Standards which detail specific BC elements, as good practice the WAST EPRR Department are now aligning WAS processes with this criteria.

2.7 Business continuity is mentioned in the IMTP 2021/22-2023/24 when describing the highest corporate risks (BC for recording digital patient clinical records) however it should be embedded in all processes. It sits within all strategies, from Quality and Clinical, through People and Culture, to Digital, Estates, Fleet and Volunteer.

¹ NHS Wales (2015) Emergency Planning Core Guidance

² NHS England (2021) Core Standards (Amended) [NHS England » Amended core standards for emergency preparedness, resilience and response \(EPRR\)](#)

3. Audit and assurance

Previous audits

- 3.1. An audit tracker was produced in response to a 'limited assurance' result from the 2014 audit. The audit indicated improvement was required around
- increasing the consideration given to BC in governance arrangements,
 - updating impact/risk assessments
 - communicating disaster recovery and business continuity plans
 - the frequency of testing
- 3.2. In 2017 and 2018, auditors rated the Trust as having 'reasonable assurance' with some further recommendations:
- BIA/BCP needed more depth and to be signed off by Executive Directors
 - Formalise BCP testing, ensure it is signed off at Executive level, and becomes business as usual
 - Embed BC in the Trust IMTP/LDP process
 - Align the risk management process with the Trust methodology at both Directorate and Corporate levels
 - Increase the number of staff (Resilience Officers) able to support the BCMS
 - Provision of appropriate training regarding BC
 - Monitoring through approved Governance processes
- 3.3. Work has been continuing to ensure the Trust meet these recommendations. Annual reports have been given to Audit Committee and now Finance and Performance Committee, the BIA processes is under review, exercises have been taking place to support impact analysis and plan design and review, with training provided to support those involved. EPRR Department have also increased the numbers of EPRR Officers who are now formally trained in BC and able to support the departments.
- 3.4. The Trust have a Business Continuity Policy that broadly meets the requirements of ISO22301 and is due for review in October 2022.

Business Continuity Steering Group (BCSG)

- 3.5. The BCSG is the principal mechanism for management review of the BCMS and informing Senior Management about emerging BC issues. The meetings are held quarterly and Chaired by the Trust BC Lead (Locality Manager, EPRR North). Each directorate has identified a Business Continuity representative who takes the lead in coordinating arrangements for their department.
- 3.6. The group reviews the BCMS as a whole and shares incident and exercise learning. Departments and directorates were required to review their BIAs and BCPs prior to D20 and during COVID after each wave to capture any learning, paying particular attention to changes regarding where people work and demands on ICT. Risk specific plans such as Fuel or ICT Disruption are reviewed and agreed by the BC Steering group.

- 3.7. The audit recommended representatives attend a minimum of 75% of the meetings (3 or more). This was achieved by 8 departments. 15 missed 2 or more consecutive meetings, 5 departments attended no meetings in 2021. Attendance at the meetings is recorded showing departmental engagement and, where it falls short of the recommendation from the audit the relevant AD is made aware.
- 3.8. Many of the representatives sat on the EU Exit (Op Yellowhammer and D20) planning groups as it meant their expertise could be applied to the risks for mitigation, assurance and reporting to Welsh Government.
- 3.9. As part of their remit to ensure the Trust meets its civil contingencies obligations, the EPRR team works with departments to assist in the development and delivery of plans, processes and systems. Performance Management is monitored by the EPRR Officers, through continuous status assessments of BIAs, BCPs and departmental exercising. The details are collated and shared with the BCSG on a Teams channel, so they are aware of progress.

COVID-19 Business Continuity and Recovery Team (BCRT)

- 3.10. The Business Continuity and Recovery Team are part of the Pandemic Plan structure and have worked alongside the Senior Pandemic Team looking at the Trust's recovery from the response and monitor phases of the pandemic. The Team look at future working practices and identify where changes could be made or where stability would be more beneficial.
- 3.11. Prior to COVID-19 the Trust did not have a formal recovery plan or strategy, this was created as part of the BCRT processes including recovery indicators and 'Living with COVID Checklist'.

4. Business Impact Analysis and Risk

- 4.1. A business impact analysis (BIA) is undertaken to identify
 - what the business delivers
 - the 'critical activities' required
 - potential outcomes of disruption
 - required staffing levels
 - interdependencies,
 - risks if any of these things are interrupted
- 4.2. To understand the organisation and plan for potential disruption, the key deliverables and processes need to be identified at an organisational level. By identifying the key products and functions, the critical activities (activities that must be performed to make the products/functions successful) can be described and understood.
- 4.3. By developing a high-level BIA, the departments responsible for delivering critical activities can produce their own, focused BIAs, risk assessments, and business

continuity plans. The organisation has departmental BIAs in place focusing on the departments themselves and their day-to-day business rather than being attached to strategic aims. The BIAs were reviewed after D20, and during the COVID response as our processes changed. Conversations held during the response to COVID-19 included what the Trust could ‘turn off’, and how staff could be redeployed. A high-level BIA would have been beneficial to focus these discussions for wider understanding.

- 4.4. Risks identified through BIAs are recorded, communicated to the relevant departments and dealt with holistically. They can be mitigated by designing systems to be resilient, and writing, sharing and testing of Business Continuity Plans (BCP). Any risks identified on the National Risk Register (NRR) that need to be actioned are recognised by the EPRR team through their representation on the LRF risk Groups. Effects from these risks should be understood by the departments and a collaborative method used to address them. For example, various types of extreme weather are listed on the NRR and dealt with in the Trust Severe Weather Plan. This was used during the heatwave in July 2021 and tested during the Seasonal Planning exercise in October 2021.
- 4.5. Risks held on the risk register should both drive and be driven by business continuity. Examples of risks held on the Corporate Risk Register that are associated with business continuity include:

Risk ID	Risk	Directorate	RAG
223	The Trust's inability to reach patients in the community causing patient harm and death	Director of Operations	
160	High absence rates impacting on patient safety, staff wellbeing and the trust's ability to provide a safe and effective service	Director of WOD	
245	Failure to have sufficient capacity at an alternative site for EMS Clinical Contact Centres (CCCs) which could cause a breach of Statutory Business Continuity regulations	Director of Operations	
224	Significant handover delays outside A&E departments impacts on access to definitive care being delayed and affects the trust's ability to provide a safe and effective service	Director of Quality and Nursing	
201	Damage to Trust reputation following a loss of stakeholder confidence	Director of Partnerships and engagement	

260	A significant and sustained cyber-attack on WAST, NHS Wales and interdependent networks resulting in denial of service and loss of critical systems	Director of Digital Services	
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- 4.6. Some interdependencies are self-evident, others unseen. The organisation would benefit from a system mapping exercise to look at all interdependencies as structures including ICT usage has changed over the past 2 years. A scoping exercise has been undertaken between EMS Operations and Digital to look at some of the priority systems and infrastructure, but this is an initial step which will be taken further and should be included when new organisational processes are being designed.
- 4.7. Debriefs exploring the experience of managing the waves of the Pandemic have illustrated the potential benefits of software to support our critical BC functions and store the number of plans required to manage something large scale and long duration. The Pandemic plan called for the introduction of an Evidence and Records Officer (ERO), a function provided by the Corporate team, to organise a repository where records can be kept securely for the requisite period of 25 years. It is likely that one of the outcomes of the Manchester Arena Inquiry will focus on records management, retention and security. The Hillsborough Inquiry which continued over 30 years after the incident illustrates that secure record management is now a requirement. The COVID-19 Inquiry will also be looking at evidence gathering and support of decision making.
- 4.8. WAST BIAs and BCPs are currently completed on Word documents and held on the BC Steering Group Teams Channel, with the exception of the CCC Critical Function impact Analysis Summary which is an Excel sheet in the same location. Although having these documents meets the requirements of the audits, it is difficult to cross check tasks, recovery times and interdependencies to get a clear view of organisational priorities. In a recent review of the paperwork, staff feedback was that it is difficult to follow and cumbersome.
- 4.9. There are several digital platforms that could be used to complete and host the BIAs and BCPs which have activity tracking for audit and assurance and can work as virtual 'battle boxes' hosting the relevant plans for managing issues and tracking what was used. A package has been identified that meets the organisations needs and is cost-effective. It is compatible with WAST digital structures and meets the online procurement criteria and used by other ambulance services to good effect. A business case was submitted to purchase the package but was unsuccessful.

5. Interdependencies and wider team working

- 5.1. Throughout the response to COVID, the BCRT discussed new ways of working, from a position of pause and reflect, to embracing matrix working into, during, and beyond

recovery from COVID. These discussions include how successful cross-department/directorate working has been, where staff share skill sets, knowledge, and work collaboratively.

- 5.2. Process and project design can often be performed in silos with little knowledge of the impact on or from other parts of the organisation. By looking at BC while processes, functions, or even buildings and fleet are being designed, risks can be identified, and mitigation applied and embedded from the start rather than after project completion. By managing it at source the programme could be more efficient.
- 5.3. From the BCRT meetings it is evident that similar processes take place across the Trust, but the terminology is different between workstreams and departments so not always recognised. If the Trust embraces matrix working and builds a culture of ensuring BC concepts and assurances are the norm through process planning, development and review, it will become part of the foundations as opposed to auditing and exploration after the fact.

6. Trust plans

- 6.1. The Trust holds generic response plans, such as the Incident Response Plan (2021), departmental business continuity plans, and risk-specific plans. The description of business continuity is also held in the Incident Response Plan, and the Notification and Escalation Procedure explains who should be notified both in and out of hours.
- 6.2. The Departmental BC plans are set to a template so all departments have what they need to act should a disruption occur. These plans and their format require a detailed review through exercising scenarios that test each of the sections (disruption to staffing, estates, ICT). In doing so, the management structure will be clarified, communications internally and externally explored, the initial actions and those to recover the activities explained.
- 6.3. The Pandemic Flu Plan was activated in March 2020 and reviewed and updated after the Wave One debrief. This became a Pandemic Plan to ensure it allowed alignment with Pandemic planning assumptions provided through the National Risk Register but also gives the flexibility to manage an incident regardless of the pathogen causing the pandemic. This has subsequently been updated again following the debrief on wave two.
- 6.4. The Fuel Disruption Plan (2021) has been reviewed in line with the current guidance from UK Government. The fuel disruption that occurred in October 2021 tested the Trust's plan in principle and it was subsequently agreed through SLT. As fuel costs rise there are more comments on social media relating to suggested protests. This potential disruption will be mitigated by strong partnership working and maintenance of situational awareness through effective communication and planning.
- 6.5. The Severe Weather plan has been updated and circulated. An earlier iteration was utilised at the beginning of 2021 due to snow and ice affecting EMS and NEPTS response, the most recent version was applied during a heatwave in July 2021.

6.6. The D20 (EU Exit) plan was further developed and refined as necessary to support our move through the Transition phase along with a separate risk register. As the plan included disruption to supplies it could be used as a basis for working on other planning assumptions such as interruptions during COVID recovery. As part of the D20 planning

- Fleet worked with Mercedes and Renault to ensure spare parts for ambulances were being stored in the UK
- Fuel bunkers were set to maximum levels and locked down
- Shared services maintained sufficient stock items and overstocked others to keep a buffer level
- Clinical logistics team identified non-stock items not available through shared services, EMT approved purchase of additional stock
- Welsh Government worked with Shared Services to maintain emergency stock at a storage facility in south Wales

7. Exercises

7.1. The BC schedule of testing was developed and approved to ensure annual testing of the Trust's plans as part of a risk assessment, planning, training, exercising, review cycle. The schedule had been developed to exercise all departments, often testing them as part of a multi departmental exercise to assist with communication and identifying interdependencies. The schedule was suspended during COVID although exercises and 'live testing' took place.

7.2. All departments have tested in real time in 2020 and reviewed their plans accordingly. Immediately prior to the pandemic, the EPRR Department devised 'Exercise Fuchsia Flamingo' focusing on a loss of staff. It looked at pandemic planning assumptions around staff abstraction and encouraged leads to consider how they would continue their activities in the absence of key or large numbers of staff. It was designed to allow departments to test in their own time and lead the exercise themselves. Smaller departments found themselves more stretched than larger departments and potentially required more assistance. The exercise received positive feedback and the benefits were published in the Finance Academy newsletter in November 2020.

7.3. In September 2020 and October 2021, the EPRR Officers facilitated the annual Trust-wide seasonal pressures BC exercise incorporating numerous departments. It was a dual-platform exercise run in part over Teams while some staff in each region co-located. Both sessions were well attended.

7.4. In the latter part of 2020, several departments including ICT took part in Exercise Draig Goch, a Welsh Government collaboration with Emergency Planning College and the National Cyber Security Centre. It was held in each Local Resilience Forum (LRF) area to look at planning assumptions and arrangements in place to highlight

interdependencies and knock-on effects if one or more partner agency lost ICT. The scenario was of Deliberate Denial of Service (DDoS) using ransomware, part of the National Risk Register, while flooding was being managed.

- 7.5. With recognition of cyber security and its place on the National Risk Register, a proposal to look at the Trusts digital dependencies was raised through SLT. Digital and EPRR collaborated to collect data from EMS Operations to explore dependencies and interdependencies. This was used to design Exercise Joshua, a multiplatform exercise held in March 2022, which explored the digital outcomes of power outage and cyber attacks on the Trust. The output of the exercise has driven the design of the risk specific BC plan for Critical ICT Disruption. This plan will be tested in Ex Joshua 2 July 2022.
- 7.6. Departments have been advised that if they are involved in any BC incident, they should record their findings in a post incident report and update their BIA's & BCP's accordingly. These documents can be held on the appropriate Teams channels for information sharing and joint learning and discussed in the Business Continuity Steering Group for wider learning.
- 7.7. The BC Steering Group and EPRR Department propose that a suite of 'off the shelf' exercises are written for the BC leads to deliver over the course of a year to test their own BIA and BCP. The format would be similar to Ex Fuchsia Flamingo. This testing should be completed in conjunction with other departments recognised as dependants or dependencies and delivered face to face, via Teams or a blended approach. The exercises would cover
 - Staffing loss
 - Service and supplier disruption
 - Premises loss
 - ICT disruption
- 7.8. Outcomes and action plans would be held in a post-exercise report and discussed by the Business Continuity Steering Group and can be summarised for submission as an appendix to future reports into Finance and Performance Committee for assurance. The BC Lead for the department would be responsible for delivery of the action plan linked to their risks on Datix.
- 7.9. For specific risks, identified via the exercises or other paths such as incidents or debriefs, finite pieces of work such as the Operations/ICT scoping exercise will take place and be coordinated through the BCSG and its members.
- 7.10. Exercises also support the scoping of future risks during process design. The BC Steering Group have suggested power outage exercises, particularly for estate used by multiple departments, and discussion around future resilience of our developing fleet. This type of discussion should be incorporated in projects such as ePCR and Cardiff station to ensure resilience is built in from the beginning.

7.11. The testing of plans including REAP, CSP, and Severe Weather through actual incidents should be recognised and recorded with outcomes discussed at the BCSG. This could be initiated through the logging of an incident on Datix, through debriefs and inclusion on the Organisational Lessons Identified Spreadsheet held by EPRR and overseen by SOT.

8. Training

8.1. Business continuity training has previously been delivered by the EPRR Officers using a face-to-face package with the focus of being on the departmental BC representatives. Training was put on hold due to the Pandemic with a view to delivering it through an online platform. A UK Government BC information package has been shared on the BC Steering Group to ensure they have a common understanding of BC for their role.

8.2. A preliminary discussion has taken place in BC Steering Group to look at what training is required, it was agreed the following cohorts have different needs which can be met but will be explored in a task and finish group.

- Executive/Director level - a short presentation at a meeting to give clarity regarding roles, responsibilities, and organisational requirements
- Assistant Director level - a workshop covering roles and responsibilities, agreement of the Trust's high-level BIA, supporting the provision of leadership to the BC Leads.
- BC Leads - a workshop covering BC theory and how they might approach their departmental contribution.
- Use of and access to BC Plans should be incorporated in induction sessions for people new to a department. As a minimum they should know what to do and who to contact should they lose access to their place of work (loss of premises).

8.3. The Business Continuity Institute runs Business Continuity Awareness Week annually in May (#BCAW2021 #BCAW2022 on social media), the Trust takes the opportunity to align with this to provide information to staff. In 2021 the EPRR Department worked with Corporate Communications to put different information on Siren each day, the theme was 'Back to Basics'. The metrics from Siren indicated minimal engagement. When a BC Incident due to system pressures was publicised, questions posted on the WAST Facebook page indicated staff were still not aware of what BC is. EPRR Department are working with Corporate Communications to further explore how to address knowledge gaps and intend to join BC Week again in 2022.

9. Recommendations

9.1. The following recommendations are made with a view to strengthening the Trusts resilience and reducing likelihood and impact of disruption to the delivery of services:

- **NOTE** the review of the Trust Business Continuity Management System to assist in identifying and mitigating risks through a structured process and putting robust plans in place
- **NOTE** the review of the business case to support the implementation of Business Continuity software (initially costed at £100,000 revenue cost for a 5 year package or £22k per annum)
- **NOTE** the system mapping to identify priority digital infrastructure and systems and strengthening cross-department working to highlight interdependencies.

NOTE the aspiration to create a culture of business continuity considerations in any system, process, fleet or estate design and delivery through the project management

10. Summary

- 10.1. The Trust has been through very challenging times and, unfortunately, challenges will continue. The National Risk Register includes aspects such as fuel disruption, local and national power outages, and cyber-attacks. Further pressures on the health systems could negatively impact our ability to deliver an appropriate service to the communities we serve and breach both our commissioning contractual obligations and legal duties under the CCA (2004).
- 10.2. By having a mature, robust business continuity management system that is embedded in the foundations of our business, the Trust will be able to mitigate some of the risks to be faced in the future. This can be done by reviewing and enhancing what we do and how we think about things, by engaging trained and knowledgeable staff in the right processes at the right time, and ensuring the question ‘What if...?’ can be answered.



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Ymddiriedolaeth GIG
Gwasanaethau Ambiwylans Cymru
Welsh Ambulance Services
NHS Trust

AGENDA ITEM No	14
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	0

EPRR Document Tracker

MEETING	Finance and Performance Committee
DATE	18/06/2022
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Head of Service - EPRR and Specialist Operations
CONTACT DETAILS	Clare Langshaw. Clare.langshaw@wales.nhs.uk

CORPORATE OBJECTIVE	8
CORPORATE RISK (Ref if appropriate)	
QUALITY THEME	2, 3, 5, 7
HEALTH & CARE STANDARD	1.1, 2.1, 2.4, 3.1, 3.5, 7.1

REPORT PURPOSE	
CLOSED MATTER REASON	

REPORT APPROVAL ROUTE

WHERE	WHEN	WHY
Senior Leadership Team	12 July 2022	Noting
Executive Management Team	13 July 2022	Noting
Finance & Performance Cttee	18 July 2022	Noting

1. SITUATION

- 1.1. The EPRR team maintains a register of the plans it has produced to mitigate the risks presented to the Trust. This register does not include Trust plans, procedures or policies managed by other departments within the Trust. This register only covers the plans that the EPRR team are responsible for maintaining.

2. BACKGROUND

- 2.1. The EPRR team is responsible, in line with the Civil Contingencies Act 2004, for assessing the risks presented to the Trust and for putting in place measure and procedures to mitigate the identified risks.
- 2.2. Under the CCA (2004) Category 1 responders are required to maintain plans for preventing emergencies; reducing, controlling or mitigating the effects of emergencies in both the response and recovery phases
- 2.3. Emergency plans may take the form of generic plans - which set out the core of a Category 1 responder's response to, and recovery from, any emergency or specific plans dealing with particular hazards or sites. WAST has plans that cover both of these categories.
- 2.4. Three aspects of performing the organisation's functions in an emergency are identified within the Act:
 - 2.4.1. maintaining plans for preventing the emergency;
 - 2.4.2. maintaining plans for reducing, controlling or mitigating its effects;
 - 2.4.3. maintaining plans for taking other action in connection with the emergency.
- 2.5. In 2021 the team identified that the number of plans being written by the team had expanded and there was not a clear register of when the plans needed to be reviewed and updated.
- 2.6. The EPRR plan register does not include those plans or Operational orders that are developed for specific, timed risks, such as New Year's Eve, events or specific public order incidents.
- 2.7. Best practice indicates that emergency plans should be reviewed every 3 years, if the risk alters or if learning indicates the plan should be updated.

3. ASSESSMENT

- 3.1. The document tracker has been maintained by the EPRR team since 2021. A recent review of the register identified that the document did not have a "dashboard" that could easily show the status of the plans, it also did not have members of the team allocated to maintain the individual plans. The updated register now has a dashboard to allow for easy review of the status of the documents, however due to the EPRR team not being fully established at present and the changes in roles due to the LM-EPRR Central returning from

secondment, not all plans have been assigned to individuals within the team, this will be completed by the end of August.

3.2. The EPRR Document Tracker allows the Trust to assess the status of our preparedness under the CCA 2004 to mitigate against the known risks within the Trust's response area within Wales.

3.3. Where documents are overdue review, Committee can be assured that actions are in progress (as detailed) and that updates should be completed by end Q2.

4. RECOMMENDATIONS:

4.1. That SLT **RECEIVE and DISCUSS** the tracker

4.2. That SLT **APPROVE** onwards presentation to EMT and F&P committee for assurance purposes.



AGENDA ITEM No	14.1
OPEN or CLOSED	OPEN
No of ANNEXES ATTACHED	1

EPRR Document Tracker

MEETING	Finance and Performance Committee
DATE	18 th July 2022
EXECUTIVE	Lee Brooks, Executive Director of Operations
AUTHOR	Clare Langshaw, Head of Service- EPRR & Specialist Operations
CONTACT	Clare Langshaw. Clare.langshaw@wales.nhs.uk

EXECUTIVE SUMMARY

The EPRR team maintains a register of the plans it has produced to mitigate the risks presented to the Trust. This register does not include Trust plans, procedures or policies managed by other departments within the Trust. This register only covers the plans that the EPRR team are responsible for maintaining.

The EPRR team is responsible, in line with the Civil Contingencies Act 2004, for assessing the risks presented to the Trust and for putting in place measure and procedures to mitigate the identified risks.

Under the CCA (2004) Category 1 responders are required to maintain plans for preventing emergencies; reducing, controlling or mitigating the effects of emergencies in both the response and recovery phases

Emergency plans may take the form of generic plans - which set out the core of a Category 1 responder's response to, and recovery from, any emergency or specific plans dealing with particular hazards or sites. WAST has plans that cover both of these categories.

Three aspects of performing the organisation's functions in an emergency are identified within the Act:

- maintaining plans for preventing the emergency;
- maintaining plans for reducing, controlling or mitigating its effects;
- maintaining plans for taking other action in connection with the emergency.

In 2021 the team identified that the number of plans being written by the team had expanded and there was not a clear register of when the plans needed to be reviewed and updated.

The EPRR plan register does not include those plans or Operational orders that are developed for specific, timed risks, such as New Year's Eve, events or specific public order incidents. Best practice indicates that emergency plans should be

reviewed every 3 years, if the risk alters or if learning indicates the plan should be updated.

RECOMMENDATIONS

Finance & Performance Committee are asked to:

1. Note that documents outstanding the review are to be allocated by end of August
2. Receive this report for assurance on the process for maintaining currency of EPRR plans and relevant documents

KEY ISSUES/IMPLICATIONS

The EPRR document tracker does not include those plans or Operational orders that are developed for specific, timed risks, such as New Year's Eve, events or specific public order incidents.

Best practice indicates that emergency plans should be reviewed every 3 years, if the risk alters or if learning indicates the plan should be updated. This can be challenging to ensure all of the EPRR plans are accurately maintained.

A recent review of the register identified that the document did not have a "dashboard" that could easily show the status of the plans, it also did not have members of the team allocated to maintain the individual plans. The updated register now has a dashboard to allow for easy review of the status of the documents, however due to the EPRR team not being fully established at present and the changes in roles due to the LM-EPRR Central returning from secondment, not all plans have been assigned to individuals within the team, this will be completed by the end of August.

Where documents are overdue review, Committee can be assured that actions are in progress (as detailed) and that updates should be completed by end Q2.

REPORT APPENDICES

Appendix 1 – SBAR
Appendix 2 – EPRR Plan Register

REPORT CHECKLIST

Confirm that the issues below have been considered and addressed		Confirm that the issues below have been considered and addressed	
EQIA (Inc. Welsh language)	Y	Financial Implications	Y
Environmental/Sustainability	Y	Legal Implications	Y
Estate	Y	Patient Safety/Safeguarding	Y

Ethical Matters	Y	Risks (Inc. Reputational)	Y
Health Improvement	Y	Socio Economic Duty	Y
Health and Safety	Y	TU Partner Consultation	Y